Vedolizumab (Entyvio)

Provider Order Form rev. 7/29/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ K50. ____: Crohn's Disease ☐ K51. ____: Ulcerative Colitis

☐ Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Entyvio 300mg IV in 250ml NS over a period of 30mins, flush with 30ml NS.

FREQUENCY *(Choose one)*

☐ Induction: week 0, 2, 6, and then every 8 wks
☐ Maintenance: every 8 weeks
☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____
☐ CMP ☐ at each dose ☐ every: _____
☐ LFT ☐ at each dose ☐ every: _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- abnormal vital signs, signs/symptoms of illness or active infection
- New onset fatigue, anorexia, abdominal pain, dark urine, or jaundice
- planned/recent surgical procedures
- neurological changes
- Recent live vaccines

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, colonoscopy, history of fistula, history of hospitalization for bleeding

Required Labs: Negative TB within 12 months, CRP, ESR, fecal calprotectin, Negative hep B

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.