

# Vedolizumab (Entyvio)

Provider Order Form rev. 3/30/2026



## 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 and Maintenance: week 0, 2, 6, and then every 8 weeks  
 Maintenance: every 8 weeks  
 Every \_\_\_\_ weeks  
 Induction only: Week 0 and 2.

## 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.