vitalcare of CENTRAL MISSISSIPPI

Fountains Infusion Center

159 Fountains Blvd. Madison, MS 39110
Phone: 601.859.8200 Fax: 601.859.8201

ENTYVIO (VEDOLIZUMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis
☐ **Required Labs:** TB Test & Baseline Liver Enzymes

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

J Code: J3380

Diagnosis:

☐ Crohn's Disease _______________

☐ Ulcerative Colitis _______________

ENTYVIO ORDERS

Entyvio Dose: ☐ 300mg IV to be infused over 30 minutes **Refills** _________

Frequency: ☐ Week 0 , 2, 6, and then Every 8 weeks or ☐ Every _____weeks

Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Order:____

Pre-Medication Orders: Tylenol 650mg PO, please choose one antihistamine:

☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO
☐ Other ______________________________

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	