Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

# ENTYVIO (vedolizumab)

## PATIENT DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____ M: ☐ F: ☐ Address: _____

Phone: _____ City, State, Zip: _____

Email: _____

Allergies:

## PRIMARY DIAGNOSIS

ICD-10 Code:

## DOCUMENTATION (PLEASE ATTACH)

☐ **Clinical / Progress Notes, Labs, Tests supporting primary diagnosis**
TB status and date (attach results)

**Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider**

## PRE-MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Loratadine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

## PRIMARY MEDICATION ORDER

**Dosage**

☐ 300mg IV

**Patient Weight:**

_____ lbs

_____ kg

**Frequency**

☐ Dose at weeks 0, 2, and 6, then every 8 weeks
☐ Dose every _____ weeks

☐ Entyvio (vedolizumab) pen or prefilled syringe subcutaneous injection 108 mg/0.68 mL every 2 weeks

## NOTES

## ORDERING PROVIDER

Provider Name: _____ NPI: _____

Practice Name: _____ Phone: _____

Office Contact: _____ Fax: _____

Practice Address: _____

City, State, Zip: _____

**Provider Signature:** _____ Date: _____