Vedolizumab (Entyvio)

Provider Order Form

Newport Superior Infusion
1501 Superior Ave, Suite 202
Newport Beach, CA 92663
Phone: 949-601-6001
Fax: 866-542-8631

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☐ Provide nursing care per Newport Infusion Standard Procedures

☐ Hepatitis B status and date (list results and attach clinicals)
_____

RECOMMENDED PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) 125mg IV

PRE-MEDICATION ORDERS

☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20mg PO
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

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

THERAPY ADMINISTRATION

☑ **Vedolizumab** (Entyvio) subcutaneous injection. For subcutaneous use in thigh only

- Dose
  - ☐ Initial: Infuse 300mg IV over ~30 minutes at weeks 0, 2, and week 6. Then infuse 300mg IV every 8 weeks thereafter
  - ☐ Maintenance:Infuse 300mg IV over ~30 minutes every 8 weeks

Quantity:

☐ 1 vial
☐ _____

Refills: ☐ Zero / ☐ for 12 months
☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Date**

Provider Signature