oasis
FAMILY HEALTH NP RN

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Entyvio (Vedolizumab)

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ______________________ DOB: __________

NKDA ☐ Allergies: ______________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

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

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ TB status & date (list results here & attach clinicals)

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PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: ______________________
Dose: __________ Route: __________
Frequency: ______________________

THERAPY ADMINISTRATION

☐ **Vedolizumab** (Entyvio) in 250ml 0.9% sodium chloride or lactated ringer's, intravenous infusion

- Dose: ☐ 300mg
- Frequency: ☐ induction: week 0, 2, 6, and then every 8 wks
- ☐ maintenance: every 8 weeks / ☐ other: ______________________
- Infuse over 30 minutes

☐ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ __________
(if not indicated order will expire one year from date signed)

* Exercise caution when considering the use of Entyvio in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: __________ Referral Coordinator Email: __________
Ordering Provider: __________ Provider NPI: __________
Referring Practice Name: __________ Phone: __________ Fax: __________
Practice Address: __________ City: __________ State: ______ Zip Code: __________

Provider Name (Print) ______________ *Provider Signature* ______________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK