

ENTYVIO (VEDOLIZUMAB) IV INFUSION ORDER FORM

Full Name: Date of Birth:

Phone Number: Email Address:

Address:

Weight: lb/kg Allergies: ☐ NKDA ☐

Treatment Status: ☐ New ☐ Continued **Last Treatment Date:**

DIAGNOSIS (ICD-10 SELECTION)

☐ K50.90 – Crohn's disease, unspecified ☐ K51.50 – Left-sided ulcerative colitis

☐ K51.90 – Ulcerative colitis, unspecified

☐ K50.80 – Crohn's disease of both small and large intestine

☐ Other: ☐ ICD-10 CODE:

INFUSION ORDER

Induction Phase:

☐ 300 mg IV at Weeks 0, 2, and 6

Maintenance Phase:

☐ 300 mg IV every 8 weeks

☐ Alternative: 300 mg IV every _____ weeks

☐ Infuse over at least 30 minutes

☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other:

LINE USE & ACCESS

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard injection protocol

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☒ Kaison Infusion Center Protocol (www.kaisoninfusion.com)

☐ Other - please fax preferred reaction orders to (405) 237-6305

PREMEDICATION (OPTIONAL)

☐ Acetaminophen: ☐ 650 mg ☐ PO ☐ PO ☐ IV

☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone: ☐ 125 mg ☐ IV

☐ Famotidine: ☐ 20 mg ☐ IV

☐ Other: Dose: Route:

LABORATORY MONITORING

☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ TB Screening ☐ Other:

Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other:

☐ Physician office will order labs only

CLINICAL DOCUMENTATION CHECKLIST

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

ORDERING PROVIDER & DEMOGRAPHICS

Name: NPI: LICENSE #:

Contact: Phone: Fax:

Email: Signature: Date: