Fax: 561-516-6626 | Email: Info@infuseone.com | Phone: 561-337-4055

INFUSE ONE

(vedolizumab)

ENTYVIO infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Ulcerative Colitis
- ☐ _____ Crohn's Disease
- ☐ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

ENTYVIO ORDERS

DOSAGE

- ☐ 300mg IV

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

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

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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