Entyvio Product Order Form

Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Demographics

Patient Name: _____
DOB: _____
Phone Number: _____
Allergies: _____

Ordering Provider: _____
NPI: _____
Primary Care Provider: _____
Insurance Information: _____

Referral Status

☐ New Referral
☐ Dose or Frequency Change
☐ Order Renewal

Has the patient been treated for this condition previously?
☐ No ☐ Yes, medication(s): _____
_____

Diagnosis & Required Information

Diagnosis & ICD-10:
☐ Moderate to severe Ulcerative Colitis - K51.90
☐ Moderate to severe Chron's Disease - K50.90
☐ Other: _____

Required Information:
☐ Patient Face Sheet
☐ Clinical/Progress Note
☐ Labs/Tests supporting diagnosis

Medication Order

Pre-Medications:

☐ Acetaminophen (Tylenol) tablet, oral, ONCE
  ☐ 650 mg
  ☐ Other: _____

☐ Cetirizine (Zyrtec) tablet, oral, ONCE
  ☐ 10 mg

☐ Famotidine, IV
  ☐ 40 mg

☐ Methylprednisolone sodium succinate (Solu-Medrol) IV, ONCE
  ☐ _____ mg

Drug: Entyvio (Vedolizumab)

Dose:
☐ 300 mg IV
Other: _____

Frequency:
☐ Induction: week 0, 2, 6 and then every 8 weeks
☐ Maintenance: Every 8 weeks
☐ Other: _____

Labs:
☐ Complete Metabolic Panel, Routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
☐ CBC with Differential, Routine, ONCE every _____ ☐ Days ☐ Weeks ☐ Months
☐ Other: _____

☒***OSI Hypersensitivity protocol: Solumedrol, Benadryl, or Famotidine could be used in the event of a hypersensitivity reaction. Referring office will be notified if this occurs***

Physician's Signature: _____ **Date:** _____

Provider Name: _____ **Office Phone:** _____ **Office Fax:** _____

Fax completed form to (503) 540-3105

Questions? Call us at (503) 540-9999
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