Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Entyvio Order Form (vedolizumab)

Fax To: 503-540-3105

PATIENT INFORMATION

Patient Name: _______________________________ DOB: __________ Phone: ______________ Sex: ☐ M ☐ F Ht:_____ Wt: _____ ☐ lbs ☐ kg

Primary Language: ___________________ Allergies: ____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ K50.0_____Crohn's Disease, Small Intestine
☐ K50.1______Crohn's Disease, Large Intestine
☐ K50.8______Crohn's Disease, Small & Large Intestine
☐ K50.9______Crohn's Disease, Unspecified
☐ Other: _____________________________________

☐ K51.8 ___Other Ulcerative Colitis, Chronic
☐ K51.5______Left sided – Ulcerative Colitis
☐ K51.0______Universal Ulcerative Colitis, Chronic
☐ K51.9____Ulcerative Colitis, Unspecified

REQUIRED: Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy
LAB RESULTS: Include Negative TB within 12 months

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine 10 mg PO
☐ Dexamethasone: ______ mg IV
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IV
☐ Other: ______________________________

☐ Acetaminophen: _____ mg PO
☐ Famotidine: _____ mg IV
☐ Loratadine 10 mg PO
☐ Methylprednisolone: _____ mg IV
☐ Ondansetron 4 mg IV

Lab Orders

☐ CBC w/diff: every ________ ☐ weeks ☐ month
☐ CMP: every __________ ☐ weeks ☐ month
☐ Other: ________________ ☐ weeks ☐ month

Entyvio (vedolizumab)

Loading Dose (SELECT ONE)
☐ **IV:** Infuse 300 mg at weeks 0, 2, and 6

Maintenance Dose (SELECT ONE)
☐ **IV:** Infuse 300 mg every 8 weeks x 1 year
☐ **IV:** Infuse 300 mg every ____ weeks x 1 year

Adverse Events: In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**** Following each infusion, flush with 30 mL 0.9% Sodium Chloride. ****

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose: ______________________________________

PRESCRIBING INFORMATION

Prescriber Name: ____ Signature: ____

Date: _______________ NPI #__________________________________ Specialty: ____

Office phone #: ____ Office Fax #: ____