Entyvio Infusion Orders

(Vedolizumab)

San Diego Infusion Center

Please fax the following documentation to 858 764-9765:

[ ]Demographics [ ]Insurance information [ ]H&P relevant to diagnosis [ ] Current TB/ lab results
[ ]current medication and allergy list

Patient information:

Date: _____Patient Name/DOB_____

ICD10 CODE_____Diagnosis_____

Weight_____lbs/kg Height_____

Allergies_____

Prescriber information:

Prescriber Name/NPI_____

Office Address_____

Contact Person_____Phone #_____fax #_____

Premeds not indicated unless written here_____

Entyvio (vedolizumab) Dose: 300mg in 250mls 0.9% NS
Frequency: [ ] initial dose at 0, 2, 6 weeks, then [ ] q 8 weeks

Prescriber Signature_____

PRN meds administered per San Diego Infusion Center Protocol

[ ] Diphenhydramine 50mg IV [ ] Solu-Medrol 125mg IV [ ] Normal Saline Bolus 500mls IV

Prescriber Signature_____