Phone:616-954-0600 Fax: 616-954-1675

Entyvio IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: __________________________ **Patient Weight:** ________lbs / kg **Height:**___________

ICD-10 : _____________________, _________________________, ________________________

In the past year, what medications for the above diagnosis has the patient tried and failed?

☐ N/A continuation of treatment

Drug	Dose	Dates of use

TB verification *(circle one)*: **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**

Result Date: ________/_______/__________ Result *(circle one)*: **Positive** **Negative**

Labs to be collected: ☐ CMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CBC w/man diff ☐ CRP ☐ Other: _________

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_______________

Pre-Medications:

Diphenhydramine PO	25mg or 50mg	☐Yes	☐ No
Cetirizine PO	10mg	☐Yes	☐ No
Acetaminophen PO	650mg	☐Yes	☐ No

Entyvio 300mg (vedolizumab) IV

Frequency: ☐ **Initial Dose – 0, 2, 6wks THEN q 8 wks.**

☐ **q 8 weeks**

☐ **Other:**___________

Rx Expiration Date: _____/_____/_____

Printed provider name: ____

Provider signature: ____

Office phone number: ____________________ **Fax number:** ______________________