

Entyvio Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: New Referral Dose or Frequency Change Order Renewal
 Location: Jackson Knoxville Morristown Kingsport

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (check one) M F
 Home Phone: _____ Mobile Phone: _____
 Email: _____ Last 4 of SS#: _____
 Allergies: _____ Height: _____ Weight: _____
 ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____
 TB Test (circle one): Skin Quantiferon Chest X-ray Result: _____ Date: _____

THERAPY ORDERS

- Induction: Administer Entyvio (vedolizumab) 300mg IV at weeks 0, 2, 6 THEN every eight weeks
- Maintenance: Administer Entyvio (vedolizumab) 300mg IV every eight weeks **OR**
 (specify): _____
- Nursing per Heartland Nursing Procedures (including reaction management)

PRE-MEDICATION No routine pre-medications required

- Tylenol (acetaminophen) _____mg PO Zyrtec (cetirizine) 10mg PO
- Solu-Medrol (methylprednisolone) IV 40 mg, 125 mg, other _____mg Claritin (loratadine) 10mg PO
- Benadryl (diphenhydramine) _____mg PO IV
- Other: _____

LABORATORY ORDERS

- CBC w/ DIFF each infusion Other: _____
- CRP each infusion Other: _____
- CMP each infusion Other: _____
- ESR each infusion Other: _____
- Hepatic Panel each infusion Other: _____
- Renal Panel each infusion Other: _____
- Quantiferon TB (annually) Due: _____
- Other: _____

PRESCRIBER'S INFORMATION

Prescriber Name: _____
 License #: _____ NPI: _____ DEA: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Office Contact: _____
 Office Phone: _____ Office Fax: _____
 Prescriber's Signature: _____

