CURBSIDE
INFUSION VENTURE

INFUSION ORDERS- ENTYVIO (VEDOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Other Order(s)

DIAGNOSIS AND ICD 10 CODE	
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.01
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ TB Test Results	☐ Baseline liver function tests ☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis ☐ Vedolizumab level and antibody test results (if changing dose or frequency)
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Initial Dosing	☐ Entyvio 300mg IV at Week 0, 2, 6 then Every 8 Weeks
Maintenance Dosing	☐ Entyvio 300mg IV Every 8 weeks
Alternative Dosing	☐ Entyvio 300mg IV Every _____ weeks
Refills: ☐ X 6 months	☐ X 1 year ☐ _____ doses

PREMEDICATIONS
☐ Acetaminophen 650mg PO prior to Entyvio infusion
☐ Diphenhydramine 25mg PO prior to Entyvio infusion
☐ Methylprednisolone 125mg Slow IV Push PRN infusion reaction
☐ Other:

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record. Contact us with questions at: (877) 428-7248
Fax Completed Form and all documentation to: (877) 428-1627