Provider Order Form

ENTYVIO (VEDOLIZUMAD)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Ulcerative Colitis K51._____ ☐ Crohn's Disease K50._____

☐ Other _____ ☐ Other: _____

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other:

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Entyvio (Vedolizumab), IV in 250ml 0.9% sodium chloride or lactated ringer's	☐ 300 mg ☐ 300 mg	Week 0, 2, 6 and every 8 weeks every 8 weeks
		☐ Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated. _____

☒ Infuse over 30 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

Provider Signature Date