Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(vedolizumab)

INFUSE ONE

ENTYVIO infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Ulcerative Colitis

☐ _____ Crohn's Disease

☐ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

ENTYVIO ORDERS

DOSAGE

☑ 300mg IV

FREQUENCY

☐ Dose at weeks 0,2, and 6, then every 8 weeks

☐ Dose every _____ weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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