

ENTYVIO® (vedolizumab)


Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Baseline liver function tests
 Clinical/Progress Notes Supporting Dx TB test results Vedolizumab level and antibody test results (If changing dose/freq.)


Primary Diagnosis

-  ICD-10 Code (required): _____
 Moderately to severe active ulcerative colitis Moderately to severe active Crohn's disease
 Other: _____

Pre-Medication

- Per violet health protocol: No recommended standard pre-medications for Vedolizumab Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____

Therapy Administration

- Induction: Entyvio 300mg IV at weeks 0, 2, 6, then every 8 weeks RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Maintenance: Entyvio 300mg IV Every 8 weeks Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 Other: _____ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
Refills: x 1 year Other: _____ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Order valid for one year unless otherwise stated Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____