(vedolizumab)
ENTYVIO
infusion orders

Please fax completed form to 973-597-0910
or
If you have any questions call 973-597-0900

LSG INFUSION SERVICES
WE INFUSE, YOU RELAX

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

☐ Loratadine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Diphenhydramine 25mg IV

☐

☐ _____ *(other)*

ENTYVIO ORDERS

DOSAGE

◉ 300mg IV

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

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

○ Dose every _____ weeks

Number of Refills _____

NOTES

_____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ NPI _____

Phone _____ Fax _____ Email _____