

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
INFUSION OFFICE PREFERENCES (Optional)		
Preferred Location* <input type="checkbox"/> Mattoon <input type="checkbox"/> Effingham		
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>		
Diagnosis and ICD 10 CODE		
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis		ICD 10 Code: K51.90
<input type="checkbox"/> Moderate to Severe Crohn's Disease		ICD 10 Code: K50.90
<input type="checkbox"/> Other: _____		ICD 10 Code: _____
REQUIRED DOCUMENTATION		
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> TB Test Results <input type="checkbox"/> Pregnancy Test (if applicable)	<input type="checkbox"/> Baseline liver function tests <input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Vedolizumab level and antibody test results (if changing dose or frequency)	
List Tried & Failed Therapies, including duration of treatment:		
1)		
2)		
3)		
MEDICATION ORDERS		
Dosing Wt for Calculations Ht: Wt: BMI:		
Initial Dosing	<input type="checkbox"/> Entyvio 300mg IV at week 0, 2, 6 then every 8 weeks	
Maintenance Dosing	<input type="checkbox"/> Entyvio 300mg IV every 8 weeks	
Alternative Dosing	<input type="checkbox"/> Entyvio 300mg IV every _____ weeks	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses		
PREMEDICATIONS		
<input type="checkbox"/> Acetaminophen 650mg PO prior to Entyvio infusion <input type="checkbox"/> Diphenhydramine 25mg PO prior to Entyvio infusion <input type="checkbox"/> Methylprednisolone 125mg Slow IV Push PRN infusion reaction <input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS		
PRESCRIBER INFORMATION		
Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

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: Fax Completed Form and all documentation to:	<input type="checkbox"/> MATTOON 1000 Health Center Dr. Ph. 217-258-4150 Suite 204 Fax 217-348-2579 Mattoon, IL 61938	<input type="checkbox"/> EFFINGHAM 901 Medical Park Dr. Ph. 217-342-7500 Suite 201 Fax 217-342-7499 Effingham, IL 62401
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Effective Date: 4/20/23

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INFUSION ORDERS - ENTYVIO (VEDOLIZUMAB)

Clinics Scan to: Physician Orders