RESTORE HEALTH
INFUSION AND WELLNESS

ENTYVIO

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ K51.9 (Ulcerative Colitis) ☐ K50.9 (Crohn's disease) ☐ Other: _____

Allergies: _____ Weight: _____ ☐ Kg ☐ Lbs Height: _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT INFORMATION

ENTYVIO (Vedolizumab)

Route: Intravenous Infusion

Dose: 300mg

Frequency:

☐ Induction: Once at week 0 and 2

☐ Maintenance: Once every 8 weeks

Quantity: _____ Refills: _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

_____

_____

_____

Provider Name: _____ Provider Signature: _____ Date: _____