MIC | METRO INFUSION CENTER

INFUSION ORDERS- ENTYVIO (VEDOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Baseline liver function tests
☐ Patient demographics AND insurance information	☐ Clinical/Progress notes
☐ TB Test Results	☐ Labs and Tests supporting primary diagnosis
	☐ Vedolizumab level and antibody test results (if changing dose or frequency)
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
3)	

MEDICATION ORDERS		
Initial Dosing	☐	Entyvio 300mg IV at Week 0, 2, 6 then Every 8 Weeks
Maintenance Dosing	☐	Entyvio 300mg IV Every 8 weeks
Alternative Dosing	☐	Entyvio 300mg IV Every _____ weeks
Refills: ☐ X 6 months	☐ X 1 year	☐ _____ doses

PREMEDICATIONS
☐ Acetaminophen 650mg PO prior to Entyvio infusion
☐ Diphenhydramine 25mg PO prior to Entyvio infusion
☐ Methylprednisolone 125mg Slow IV Push PRN infusion reaction
☐ Other:

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627
Fax completed form and all documentation to (866) 507-1164
All information contained in this form is strictly confidential and will become part of the patient's medical record.