



PLACE LABEL HERE

Name: _____

Unit #: _____

Account #: _____

Entyvio (Vedolizumab) Infusion Faxed Order

Infusion Center Fax numbers:

MVH Middletown/AMC: 513-974-5023	MVH Troy/UVMC: 937-440-4503
MVH South: 937-641-2676	MVH Greenville: 937-641-7205
MVH North: 937-641-2378	

Patient Name: _____ **DOB:** _____

Patient MRN #: _____

Patient Allergies: _____

Insurance: _____

*Please attach a copy of the patient's insurance information to this order

Diagnosis:

- Crohn's disease, regional enteritis of unspecified site (K50.90)
- Ulcerative colitis, Ulcerative (chronic) enterocolitis (K51.00)
- Other: _____

Intravenous Therapy:

- Place IV with each infusion and remove when infusion completed
- Saline Flush 10mL after infusion and PRN
- Heparin Flush (100 units/ml) 5mL PRN for Implanted Port de-access
- Entyvio (Vedolizumab) (HCPCS C9026)

Dose:

- 300mg
- Other: _____

Frequency:

- Series: initial dose, then at 2 weeks, and at 6 weeks, and then every 8 weeks
- Every 8 weeks
- Other specified frequency: _____

Administration:

- IV over 30 minutes
- Other: _____

Infusion Reaction Protocol:

- Premier Health standard infusion reaction protocols

Additional Orders: _____

Provider Signature: _____ **Date/Time:** _____

Printed Provider Name/Phone Number: _____

Orders complete by RN: _____ DATE/TIME: _____

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