



Crohn's Disease / Ulcerative Colitis

Patient Name: _____

DOB: _____ Phone: _____

*** Include a facesheet with demographics and insurance information ***

DIAGNOSIS: _____ ICD-10: _____

*** Include an H&P, clinical notes and recent labs to support diagnosis ***

Clinical Assessment

Patient is new to therapy Week 0,2,6 and every 8 weeks thereafter

Patient is currently on Therapy

Start Date: _____

Last Infusion Date: _____

Current Weight: _____ kg mg

TB Test Results and Date: _____

Hep B Test Results and Date: _____

Other therapies Tried and Failed (Please list):

Unresponsive to Conventional Treatment

Inadequate Response to Methotrexate (Dose: _____)

Requested labs and Frequency Order:

No labs ordered

Allergies: _____

Infusion supplies and Ambulatory Infusion Pump (E0780) are authorized to be dispensed per pharmacy protocol and medication administration guidelines. Hypersensitivity / Anaphylaxis Reaction per pharmacy protocol (reverse)

ORDERING PROVIDER

Signature: _____ Date: _____

Provider: _____ NPI: _____

Phone: _____ Fax: _____

Prescription Information

ENTYVIO (vedolizumab) 300 mg vial

_____ DOSE

_____ FREQUENCY

_____ REFILLS

REMICADE

INFLECTRA

**May Substitute
Biosimilar**

_____ mg/kg *weight based*

_____ mg *flat-dose*

_____ FREQUENCY

_____ REFILLS

SKILLED NURSING - PER ADMINISTRATION

PRE-MEDICATION - 30 min prior to administration

Acetaminophen (Tylenol) _____ mg

Diphenhydramine _____ mg PO IVP

Solu-Medrol _____ mg IVP

Other: _____