Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER
Vedolizumab (ENTYVIO)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _______/_______/________

***Please fax a copy of the following patient information**:
☐ Demographics ☐ Insurance Information ☐ Current Lab Results
☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

Patient Information

Allergies: ______________________________

Weight: ___________ lbs/kg Height: _______

Diagnosis: ______________________________

ICD-10: ______________________________

Provider Information

Printed Provider's Name: ______________________

Signature: ________________________________

NPI: __________________ Date: ___/_____/______

Phone: (____)_____-_______ Fax: (____)____-_______

Office Address: _____________________________

Contact Person: _____________________________

TB TEST

Result: _________________________ Test Date: _____/______/________ ☐ Copy Attached

Pre-Medications:

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

Acetaminophen: ☐ PO ☐ 650 mg ☐ 1000 mg

Other: ☐ ____

☐ No Pre-Medications

Wait Time after Pre Medications:

☐ 20 minutes ☐ 30 minutes ☐ Other: ____________ ☐ No wait time

LABS:

☐ CBC w/diff ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ CMP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ CRP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ Other: ___________ ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ No labs needed

ENTYVIO (vedolizumab) IV DOSAGE

Dose: 300 mg / 250 mL 0.9% NS

Frequency: ☐ Initial Dose at 0, 2, 6 weeks, then ☐ q 8 weeks

Other: ________________________________ **Duration:** _________________________________