vitalcare INFUSION SERVICES of SIOUX FALLS

1020 S Cliff Ave., Sioux Falls, SD 57104
P / 605-220-7824 · F / 605-220-7980
www.vitalcaresiouxfalls.com

ENTYVIO (VEDOLIZUMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
☐ TB and Hepatitis B documentation

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Crohn's Disease (ICD-10: _____)

☐ Ulcerative Colitis (ICD-10: _____)

Labs:

Required labs to be drawn by: D Infusion Clinic D Referring Physician

ENTYVIO ORDERS

Entyvio Dose: 0300mg IV to be infused over 30 minutes

Frequency: ☐0,2,6 then Every 8 weeks or D Every___ weeks

TB: ☐TB Test Attached

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD.

Required Lab: Baseline Liver Enzymes (within 6 months, preferably)

**Date of last D Remicade D Humira ☐Stelara D Other:___ dose:__ _

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	