CIVIC INFUSION

FAX: 203-724-4838

(vedolizumab)

249 Danbury Rd, Wilton, CT 06897

400 Columbus Ave, Valhalla, NY 10595

127 Washington Ave, N. Haven, CT 06473

_____

ENTYVIO infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Ulcerative Colitis

☐ _____ Crohn's Disease

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

ENTYVIO ORDERS

DOSAGE

◉ 300mg IV

FREQUENCY

○ Dose at weeks 0, 2, and 6, then every 8 weeks

○ Dose every _____ weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

HEIGHT _____ ft _____ in

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____