

Entyvio® (vedolizumab) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:	Patient Email:		
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per VIVO protocols.

ENTYVIO THERAPY ADMINISTRATION

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- OTHER _____

300mg IV on week 0,2, 6 and every _____ weeks
300mg IV every _____ weeks

PREMEDICATIONS

- acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- methylprednisolone (Solu-Medrol) 40mg 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
- Dose: _____ Route: _____
- Frequency: _____

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Medication List and H&P

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) _____ Provider Signature _____ Date _____

Fax Numbers	Nevada: 702-489-5744	Massachusetts: 203-724-4838	Have a Question? (720) 902-4111 Email Referrals To: referrals@vivoinfusion.com
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 203-724-4838	
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838	