Site of Care
☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

☐ Ulcerative Colitis, ICD 10: _____

☐ Crohn's Disease, ICD 10: _____

☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25 mg PO ☐ Methylprednisolone (Solu-Medrol) ____ mg IVP

☐ Other: _____ Dose: _____ Route: _____
☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Entyvio	☐ 300 mg	☐ IV	☐ Weeks 0, 2, 6, then every 8 weeks ☐ Every 8 weeks

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Signature: _____ Date: _____

Order valid for 1 year from date of signature unless otherwise specified here: _____