Vedolizumab IV (Entyvio IV)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐New Referral ☐Updated Order ☐Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐NKDA Allergies:

Therapy Status: ☐New to Therapy ☐Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐K50.00 Crohn's disease of small intestine without complications

☐K50.10 Crohn's disease of large intestine without complications

☐K50.90 Crohn's disease, unspecified

☐Other:

☐K51.00 Ulcerative (chronic) pancolitis without complications

☐K51.90 Ulcerative colitis, unspecified without complications

PRIMARY MEDICATION ORDER

Vedolizumab (Entyvio) in 250ml 0.9% sodium chloride or lactated ringer's, intravenous infusion

• Flush with 0.9% sodium chloride at infusion completion

• Refill for 12 months unless otherwise noted: _____

☐ ***New Start:*** 300mg IV at Weeks 0, 2, 6, and every 8 weeks thereafter.

☐ ***Maintenance:*** Entyvio 300mg IV every 8 weeks

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Entyvio

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV

☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐at each dose ☐every _____

☐ CMP ☐at each dose ☐every _____

☐ CRP ☐at each dose ☐every _____

☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772