Entyvio Order
(Vedolizumab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP
❒ H & P Relevant to the Diagnosis ❒ TB Labs ❒ Current Medications
❒ Colonoscopy / Pathology Report

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

TB TEST

Result: _____ Test Date: _____ ❒ Copy Attached

PRE-MEDICATIONS: (USUALLY NOT INDICATED)

Diphenhydramine: ❒ PO ❒ IV ❒ 25mg ❒ 50mg ❒ Pre-med ❒ PRN

Acetaminophen: ❒ PO ❒ 650mg ❒ Pre-med ❒ PRN

Other OTC: ❒ _____

ENTYVIO(VEDOLIZUMAB) IV DOSAGE

Date of Last Treatment, If Continuation:

300 mg / 250 mg mL 0.9% MS

Frequency: ❒ Initial dose at 0, 2, 6 weeks, then ❒ q 8 weeks

Other: **Duration:**

Start Date of Infusion: _____