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Patient Name: _____
DOB _____
Date of last treatment: _____

New Start



**LOUIS H.
MEDVED, MD**
INFUSION THERAPY

Entyvio® (vedolizumab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Crohn's Disease
(ICD-10)

_____ Ulcerative Colitis
(ICD-10)

_____ Other: _____
(ICD-10) (description)

- Hold infusion and notify provider for:
 - Abnormal vital signs
 - Fever, signs or symptoms of illness or active infection,
 - New onset fatigue, anorexia, abdominal pain, dark urine or jaundice
 - Planned/recent surgical procedures
 - Neurological changes
 - Recent live vaccinations
- If infusion-related reaction occurs, stop infusion, notify provider and follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Lab orders:

CBC w/diff CMP Other:

Indicate frequency:

Administer vedolizumab 300 mg in 250 mL 0.9% sodium chloride over a period of 30 minutes. Flush with 30 ml 0.9% sodium chloride following infusion.

Frequency (chose one):

On weeks 0, 2, 6, then every 8 weeks

Every 8 weeks

Every _____ weeks

Additional Orders:

Provider (please print): Louis H. Medved Other _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.