Entyvio (vedolizumab)

Provider Order Form rev.5/20/2022

AleraCare
A Healthcare Solutions Company
www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ K51.80 Ulcerative colitis

☐ K51. 90 Ulcerative colitis, unspecified, without complications

☐ K50.90 Crohn's disease, unspecified, without complications

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

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

☐ Other: _____

PRE-TREATMENT

☐ 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: _____

MEDICATION ORDER

Entyvio (vedolizumab)

Dose: ☐ 300mg IV over 30 min

Frequency:

☐ week 0, 2, 6 and then every 8 weeks thereafter

☐ every 8 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**