Premier Health
Miami Valley Hospital

PLACE LABEL HERE

Name: _____

Unit #: _____

Account #: _____

Entyvio (Vedolizumab) Infusion Faxed Order

Infusion Center Fax numbers:

MVH Middletown/AMC: 513-974-5023	MVH Troy/UVMC: 937-440-4503
MVH South: 937-641-2676	MVH Greenville: 937-641-7205
MVH North: 937-641-2378	

Patient Name: _____ **DOB:** _____

Patient MRN #: _____

Patient Allergies: _____

Insurance: _____

*Please attach a copy of the patient's insurance information to this order

Diagnosis:

☐ Crohn's disease, regional enteritis of unspecified site (K50.90)
☐ Ulcerative colitis, Ulcerative (chronic) enterocolitis (K51.00)
☐ Other: _____

Intravenous Therapy:

☑ Place IV with each infusion and remove when infusion completed
☑ Saline Flush 10mL after infusion and PRN
☑ Heparin Flush (100 units/ml) 5mL PRN for Implanted Port de-access
☑ Entyvio (Vedolizumab) (HCPCS C9026)

Dose:
- ☐ 300mg
- ☐ Other: _____

Frequency:
- ☐ Series: initial dose, then at 2 weeks, and at 6 weeks, and then every 8 weeks
- ☐ Every 8 weeks
- ☐ Other specified frequency: _____

Administration:
- ☐ IV over 30 minutes
- ☐ Other: _____

Infusion Reaction Protocol:

☑ Premier Health standard infusion reaction protocols

Additional Orders: _____

Provider Signature: _____ **Date/Time:** _____

Printed Provider Name/Phone Number: _____

Orders complete by RN: _____ DATE/TIME: _____

**Order valid for 1 year from provider signature date*