NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Entyvio(Vedolizumab) Order Form – J3380

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Please list any premeds needed here_____

Entyvio (Vedolizumab): Crohn disease or ulcerative colitis: IV: 300 mg at 0, 2, and 6 weeks and then every 8 weeks thereafter. ***Please check all that apply****

Dose 300mg: ☐ **Initial,** ☐ **day 15,** ☐ **day 43**

Maintenance: ☐ **300mg every 8 weeks.**

Orders valid through___/___/____

Required labs: prior to treatment TB screening and LFTs prior to therapy at 6 months then as clinically indicated

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____