NEW ENGLAND
Cancer Specialists

Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

Entyvio (Vedolizumab) Order Form—J3380

Patient Name | Middle | Last | DOB

Diagnosis | Diagnosis Code

Height (cm) | Actual Weight (kg) | Allergies

Please list any premeds needed.

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

Entyvio (Vedolizumab): Crohn's 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 ◯ Week 2 ◯ Week 6 Maintenance: ◯ 300mg every 8 weeks

Orders valid through: _____

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