FUSIONDRIP
HYDRATION & WELLNESS

Entyvio (vedolizumab) IV Infusion Order Form

Phone: 614-407-1621 Fax: 614-413-3877
orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ lb/kg
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ /____

Diagnosis (ICD-10 Selection)

☐ K50.90 – Crohn's disease, unspecified
☐ K51.90 – Ulcerative colitis, unspecified
☐ K50.80 – Crohn's disease of both small and large intestine
☐ K51.50 – Left-sided ulcerative colitis
☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- **Induction Phase:**
  ☐ 300 mg IV at Weeks 0, 2, and 6
- **Maintenance Phase:**
  ☐ 300 mg IV every 8 weeks
  ☐ Alternative: 300 mg IV every _____ weeks
- ☐ Infuse over at least 30 minutes
- ☐ Refills: ☐ None ☐ 6 months ☐ 12 months ☐ Other:_____

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line

☒ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

☒ Fusiondrip Hydration & Wellness Protocol (fusiondriphydration.com)
☐ Other – please fax preferred reaction orders to 614-413-3877

Premedication (Optional)

☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Famotidine: ☐ 20 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

☐ CBC ☐ CMP ☐ CRP ☐ TB Screening
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____