VANCOUVER CLINIC® **ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER** Attn: Infusion department **Vedolizumab (ENTYVIO®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

Weight:_____lb/kg Height:_____inch/cm

Diagnostic Code ICD-10:_____ Diagnosis:_____

□ Initial Consult □ Annual Renewal

Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering.

Patients will be seen by our internal infusion clinician for purposes of providing care.

GUIDELINES FOR ORDERING:

- Send FACE SHEET and H&P or most recent chart note.
- Vancouver clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).

MEDICATIONS:

Vedolizumab (ENTYVIO®)

- ☐ Initial dosing: 300 mg in sodium chloride 0.9% 250 mL, intravenous, over 30 minutes, on week 0, 2 and 6, then every 8 weeks thereafter
- ☐ Maintenance dosing: 300 mg in sodium chloride 0.9% 250 mL, intravenous, over 30 minutes, every 8 weeks, next dose due:_____
- ☐ Other:_____

Provider's signature: _____

Provider's printed name: _____Date:_____

Please fax the completed form and pertinent information to Fax: 360-604-1776

Vancouver Clinic Outpatient Infusion Service *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245