FUSE INFUSION
175 Memorial Highway. Suite 1-1
New Rochelle, NY
10801
914-460-4891
fuse@fuseinfusion.com
914-460-4571

(vedolizumab)

ENTYVIO infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Ulcerative Colitis

☐ _____ Crohn's Disease

☐ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg IV

☐ Diphenhydramine 25mg IV

☐ Cetirizine 10mg IV

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

ENTYVIO ORDERS

DOSAGE

◉ 300mg IV

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

○ Dose at weeks 0,2, and 6, then every 8 weeks

○ Dose every _____ weeks

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____