Ambulatory Infusion Center

Parkway Medical Center
3609 Park East Drive #207
Beachwood, OH 44122

216-360-0456 TEL
216-378-9824 FAX
216-360-9449 ALT FAX

INFUSION ORDERS - ENTYVIO (vedolizumab)

Date of Referral: _______________ Infusion Location: ☐ Beachwood ☐ Middleburg Heights ☐ Painesville

Patient Information

Patient Name: ____ Date of Birth: ______________________________

Address: ____

City: ____________________________________ State: ___________________ Zip Code: __________________

Phone: _____________________________________ WT (kg): _______________ HT (in): ___________________

Diagnosis: __________________________________ ICD10 Code: ____

Allergies: ____

PLEASE FAX SUPPORTING CLINICAL DOCUMENTATION, INCLUDING MEDICAL RECORDS/PROGRESS NOTES, LABS, and INSURANCE INFORMATION (both front and back of the card) ALONG WITH THIS FORM

ENTYVIO DOSING

☐ 300 mg administered at 0, 2, 6 weeks; then every 8 weeks thereafter
☐ 300 mg administered every __________ weeks

☐ Premed Orders: ____

☐ Special Needs/Considerations: ____

Date of Last TB test (recommended): _________________________ Result: ___________________________

Prescribing Physician: ____

Address: ____

Physician Signature: ____ Date: ___________________________

Physician Phone: __________________________________ Fax: _______________________________________

LAB REQUIREMENTS and LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBING PHYSICIANS