



Atrium Health
Infusion Center

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Pineville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Southpark Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Huntersville Fax: 704-468-3401 <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC Fax: 704-512-5390 <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC Fax: 704-512-5390

Entyvio® (vedolizumab) Infusion Order (Revised 2/11/2026)

All orders with a $\sqrt{\quad}$ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
<input type="checkbox"/> NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

<input type="checkbox"/> K50.0___ - Crohn's Disease (small intestine)	<input type="checkbox"/> K51.5___ - Left sided colitis
<input type="checkbox"/> K50.1___ - Crohn's Disease (large intestine)	<input type="checkbox"/> K51.8___ - Other ulcerative colitis or unspecified
<input type="checkbox"/> K50.8___ - Crohn's Disease (small and large intestine)	<input type="checkbox"/> K51.9___ - Ulcerative colitis, unspecified
<input type="checkbox"/> K51.0___ - Universal Ulcerative (chronic) Pancolitis	<input type="checkbox"/> Other:
<input type="checkbox"/> K50.9___ - Crohn's Disease, Unspecified	

Required Documentation: (required prior to scheduling)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (<i>must include labs pertinent to medication ordered</i>)	<input type="checkbox"/> No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
Diagnostic Studies Pertinent to Medication Ordered	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment Parameters:

Hold Treatment and Notify Provider IF:

- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection

Nursing Communication:

- Start PIV/Access CVC and flush device per approved Atrium Health protocol.
- Obtain vital signs PRE-treatment and POST-treatment and PRN during the infusion
- Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

- Acetaminophen (Tylenol) 650mg PO ONCE
- Diphenhydramine (Benadryl) 25mg PO ONCE
- Diphenhydramine (Benadryl) 25mg IV ONCE
- Loratadine (Claritin) 10mg PO ONCE
- Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE
- Hydrocortisone sodium succinate (Solu-Cortef) injection 100mg IV ONCE

Infusion Therapy:

- Vedolizumab (Entyvio) 300mg IV over 30 minutes Week 0 and Week 2 Only
- Vedolizumab (Entyvio) 300mg IV over 30 minutes Week 0, Week 2, and Week 6, then:
- Vedolizumab (Entyvio) 300mg IV over 30 minutes every _____ weeks

Supportive Care Medications:

- Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). ONLY administer if not given as a pre-medication.
- Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6).
- Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

- Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	

Physician Signature: (Order expires 12 months from date of signature) No Stamp Signatures Accepted

Signature:	Date:
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