Atrium Health Wake Forest Baptist

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Wake Forest Baptist Infusion - Westchester **Fax 336-802-2389**

Entyvio® (vedolizumab) Infusion Order (Revised 08.25.2026)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) ☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
☐ K50.0____ - Crohn's Disease (small intestine)	☐ K51.5____ - Left sided colitis
☐ K50.1____ - Crohn's Disease (large intestine)	☐ K51.8____ - Other ulcerative colitis or unspecified
☐ K50.8____ - Crohn's Disease (small and large intestine)	☐ K51.9____ - Ulcerative colitis, unspecified
☐ K51.0____ - Universal Ulcerative (chronic) Pancolitis	☐ Other:
☐ 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 (*must include labs pertinent to medication ordered*)	☐ 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: If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ 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 Wake Forest Baptist 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 Wake Forest Baptist Infusion - Westchester website at

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: