



MATAGORDA REGIONAL
 MEDICAL CENTER
 MRMCM IV THERAPY SERVICES
 PHONE: 979-241-5966
 FAX: 979-241-5965

ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex: () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description: _____

PERTINENT MEDICAL HISTORY

- 1) TB test performed? Yes No Results, _____
 2) Patient diagnosed with Congestive Heart Failure? Yes No 3) Liver function test normal? Yes No
 4) Patient previously treated with Entyvio? Yes No Date: _____ 5) Hep-B antigen surface antibody test? Yes No Date: _____
 a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
 b) ADMINISTER CATH-FLO 2MG, IVP PER PORT IF PICC LINE IS SLUGGISH OR OCCLUDED, MAY REPEAT AFTER 2 HRS IF NEEDED X 1.
 c) ENTYVIO (VEDOLIZUMAB) WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 30 MINUTES WITH A 1.2 MICRON FLITER
 d) ALL LINES WILL BE FLUSHED WITH 30 ML OF 0.9% NS UPON COMPLETION OF INFUSION

PRESCRIPTION ORDERS: ENTYVIO (VEDOLIZUMAB)

Does patient have venous access? YES NO

If yes, what type: MEDIPOINT PIV PICC LINE OTHER: _____

SELECT BELOW	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES	300 MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY	WEEKS
	MAINTENANCE DOSE	300 MG	IV	ONCE EVERY	WEEKS

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	BMP	() PRIOR () POST	
	CMP	() PRIOR () POST	
	BUN/CREATININE	() PRIOR () POST	
	CRP:	() PRIOR () POST	
	ESR:	() PRIOR () POST	
	Other:	() PRIOR () POST	

NOTES/INSTRUCTIONS/COMMENTS

FLUSHES: 10 mL NS Flush Syringe PRN Heparin 500 units/5 mL Flush Syringe PRN NS 50 mL PRN

Physician's Signature _____ Time _____ Date _____

Fax completed form to the MRMCM Infusion Center at 979-241-5965.
 PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed. Reviewed 04/2026