

ENTYVIO ORDER FORM

Patient name: _____ DOB: _____ Sex : () Male () Female
SSN: _____ HT: _____ WT: _____ Allergies: _____
Street Address _____ City/State/Zip _____
Home Phone #: _____ Work #: _____ Cell #: _____

Insurance Information:

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

Physician Information:

Physician's Name: _____ Referral Contact Name: _____ Phone: _____
Address: _____ City/State/Zip _____
DEA#: _____ NPI #: _____ Fax #: _____
State License #: _____

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description) _____
Date of Diagnosis: _____

Pertinent medical history

TB test performed? Yes No Results: _____ Patient diagnosed with Congestive Heart Failure? Yes No
Liver function test normal? Yes No Comments _____
Does the patient have venous access? Yes No If Yes, what type? _____
Patient previously treated with Remicade? Yes No Date: _____
Patient had Hep-B antigen surface antibody test? Yes No Date: _____

Orders: ENTYVIO® (VEDOLIZUMAB) 300mg IV

***Normal Saline will be used to clear all lines. All MEDIPOINTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. ***

- Do not administer Heparin to this patient. Insert PIV Insert PICC

Dose: Entyvio 300mg IV in NS 0.9% 250ml, Infuse over 30 minutes then flush line with 30mL of NS

Frequency:

- Loading doses: Infusion at 0, 2, and 6 weeks, then once every _____ weeks
 Once every _____ weeks

Labs: _____

Premedication:

- Benadryl: _____ mg PO IV X1 dose
 Oxygen: _____
Other: _____

Physician's Signature _____ Date _____ Time: _____

**Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT
INSURANCE INFORMATION in order for your referral to be processed.**