



Entyvio (vedolizumab)

New Referral Continuing Treatment Medication Order Change

Patient Information:

Name: _____
 Date: _____
 DOB: _____
 SS#: _____
 Phone #: _____
 Email: _____

Physician Information:

Referring Physician: _____
 Address: _____

 Phone #: _____
 Fax #: _____

Medication Orders

Patient Weight: _____ kg Patient Height: _____ inches First Dose Maintenance Dose

Dosing: **LOADING DOSES: 300 MG IV @ 0 weeks, 2 weeks, 6 weeks, and then every 8 weeks thereafter**
 MAINTENANCE DOSE: 300 MG IV every 8 weeks

Premeds(if applicable): _____ _____

- Indication / Diagnosis:
- K51.00 Ulcerative(chronic) pancolitis w/o complications
 - K51.90 Ulcerative colitis, unspecified, w/o complications
 - K50.90 Crohn's disease, unspecified, w/o complications
 - K50.10 Crohn's disease of large intestine w/o complications
 - Other (please specify) _____
- ICD-10 (Required) _____

MD Signature: _____ **NPI#:** _____ **Date:** _____

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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