

Please fax completed form, insurance card, and clinical documentation to:

FAX: 843-793-6181

ENTYVIO ORDER	☐ New Start ☐ Maintenance: Last Dose Given		
Referring Office:	Contact Name:		Date:
Direct Phone for Contact:		Fax:	
Patient Name:		DOB:	
Allergies □ NKDA □ Allergies:			
Height: Weight: _			
Indication: ☐ K50.0 Crohn's Disease (small intestine) ☐ K50.8 Crohn's Disease (small & large intestine) ☐ K51.5 Left-sided Ulcerative (chronic) Pancetic Color C	tine) 🗆 K51.0	Crohn's Disease (large Universal Ulcerative (c Other Ulcerative (chro	hronic) Pancolitis
DRUG: ☐ Loading Doses: 300mg at weeks 0, 2 and 6 the ☐ Maintenance Only: 300mg every 8 weeks ☐ Other	·		
PREMEDICATION ORDERS: not required by PI □ Acetaminophen po: □ 1000mg □ 500mg □ 30 min prior to infusion. □ Diphenhydramine: □ 25mg PO □ 50mg PO □ 25mg IVP □ 30 min prior to infusion. □ Solu-Medrol: □ 62.5mg IVP □ 100mg IVP □ Other □ 30 min prior to infusion. □ Other □ 0ther □			
Prescriber Name:	Title:		
NPI:	DEA:		
Prescriber Signature:	Date of C	rder:	
Referrals will not be processed until we receive A □ Face Sheet / Patient Demographics □ Insurance card(s) – copy of front & back □ Last 2 clinic notes pertaining to referring diagnomoust Recent Labs (within last 4-8 weeks) – Requir □ CBC □ CMP □ TB □ Hep B Other:	osis (include ALL past	& failed therapy outco	mes)