



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) K50.1 ___ Crohn's Disease (large intestine)

K50.8 ___ Crohn's Disease (small & large intestine) K51.0 ___ Universal Ulcerative (chronic) Pancolitis

K51.5 ___ Left-sided Ulcerative (chronic) Pancolitis K51.8 ___ Other Ulcerative (chronic) Pancolitis

K51.9 ___ Ulcerative Colitis, Unspecified

Other _____

DRUG:

Loading Doses: 300mg IV at weeks 0, 2 and 6 then every 8 weeks

Maintenance Only: 300mg IV every 8 weeks

Other _____

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Methylprednisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____