



Entyvio (Vedolizumab)

INFUSION THERAPY CENTERS

New Referral Restart Medication Order Change

PATIENT INFORMATION

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

PHYSICIAN INFORMATION

Referring Physician _____
Practice Address _____
Office Contact Name _____
Contact Phone # _____ Fax # _____
NPI / TIN _____

MEDICATION ORDERS

Dose: 300mg Frequency: Initial Dose 2 weeks 6 weeks
 Patient Weight: _____kg Maintenance Every 8 weeks

Indication / Diagnosis:

- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.90 Ulcerative colitis, unspecified, without complications
- K50.90 Crohn's disease, unspecified, without complications
- K50.10 Crohn's disease of large intestine without complications
- Other (*please specify in additional information*)

Pre-treatment option:

- Benadryl 25 or 50
- Acetaminophen 500mg

Additional Information:

ICD-10 (Required) _____

MD Signature _____ Date _____

REQUIRED DOCUMENTATION

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

- 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)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- Chest Xray
- CBC with differential
- TB test (within 12 months)
- Hepatitis B-Core Ab, B SAg, B SAb
- Comprehensive metabolic panel
- COCCI
- Hepatitis C-Ab

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

AZIVinfusion.com | CALL CENTER: 602.386.4968 | FAX: 623.594.8533

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