

Fax form to:

Billings - 719.300.4068
Great Falls - 406.384.7002
Boise - 208-488-4998

Colorado Springs - 719.300.4068
Grand Junction - 970.822.7700

INFUSION ORDERS ENTYVIO (vedolizumab)

Patient's Information

Date of Referral

First Name

Last Name

M.I.

Date of Birth

Address

City

State

ZIP Code

Phone

WT (kg)

HT (in)

Diagnosis

Allergies

Please fax most recent TB test date and results.

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

ENTYVIO DOSING

300mg administered at day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter.

Refills:

Maintenance dose 300mg Q8 weeks:

Refills:

Prescribing Provider

Address

City

State

ZIP Code

Provider
Signature

Date

Provider Phone

Provider Fax