PURE
INFUSION SUITES

**Fax form to:**
Billings - 406.206.0105
Great Falls - 406.794.0555
Boise - 208.545.3214
Colorado Springs - 719.623.0085
Grand Junction - 970.404.8100

# 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