Return Completed Form To:
888.898.9113

INFUSION ORDER – ENTYVIO (vedolizumab)

Patient First Name: ___________________________________ Patient Last Name: ______________________________

Address: ____ City: ____

State: _____________ Zip Code: _______________________ Phone: ____

Referral Date: _______________________________________ Weight (kg): ____________ Height (in): ____________

Diagnosis: ____

Allergies: ____ TB Test Results: ____________________

ENTYVIO DOSING

☐ 300mg administered at day 0, two weeks, six weeks and every 8 weeks thereafter

☐ Specific dose of: ____

Prescribing Physician: ____

Address: ____________________________________ City: ____________________ State: _____ Zip: ___________

Physician Phone: ____________________________ Fax: ____

Physician Signature: ____ Date: ________________________

ICD 10 CODE: ____

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.