

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION			
Name:			DOB:
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon <input type="checkbox"/> Effingham			
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis		ICD 10 Code: K51.90	
<input type="checkbox"/> Moderate to Severe Crohn's Disease		ICD 10 Code: K50.90	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> TB Test Results <small>*Patient may be required to submit a pregnancy test prior to treatment</small>		<input type="checkbox"/> Baseline liver function tests <input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis (must be within 1 year) <input type="checkbox"/> Vedolizumab level and antibody test results (if changing dose or frequency)	
List Tried & Failed Therapies, including duration of treatment:			
1)			
2)			
3)			
MEDICATION ORDERS			
Dosing Wt for Calculations	Ht:	Wt:	BMI:
Initial Dosing	<input type="checkbox"/> J3380 Entyvio 300mg IV at week 0, 2, 6 then every 8 weeks		
Maintenance Dosing	<input type="checkbox"/> J3380 Entyvio 300mg IV every 8 weeks		
Alternative Dosing	<input type="checkbox"/> J3380 Entyvio 300mg IV every _____ weeks		
Duration	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses		
PREMEDICATIONS			
<input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Diphenhydramine 25mg IV Push or PO <input type="checkbox"/> Methylprednisolone 125mg Slow IV Push <input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS / INFORMATION			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:	Office Fax:	Office Email:	
Prescriber Signature:	Date:	Time:	

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:

Fax Completed Form and all documentation to:

☐ MATTOON

1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM

901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

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INFUSION ORDERS - ENTYVIO (VEDOLIZUMAB)

Clinics Scan to: Physician Orders