



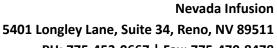
PH: 775-453-0667 | Fax: 775-470-8478

Entyvio Order Form

Patient Nar	me:			DOB:	
Phone:		Address:			
				lergies:	
DIAGNOSIS	: ∙				
_	hn's Disease ICD-10:		□ Other	r:	
	erative Colitis ICD-10:		ICD-1	LO:	
ORDER FO	R ENTYVIO (VEDOLIZUM	AB):			
	ial Dose: 300mg IV at we	•	erv 8 weeks x 1 ve	ear	
	intenance Dose: 300mg		•		
	intenance Dose: 300mg		=	ır	
	o o	,			
PRE-MEDIC	CATIONS:				
	☐ Acetaminophen 650i	mg PO			
	☐ Diphenhydramine 25	_	tec 10 mg PO		
	☐ Hydrocortisone 100r	=	=	IV	
	Additional Pre-Medic	•	_		
MAY ADMI	NISTER IF NEEDED FOR A	ALLERGIC REACTIO	N:		
☑ Nev	ada Infusion Hypersens	itivity Reaction Or	der Set		
	er:	-			
	ripheral IV, Port, Midline 10 mls NS pre/post infu		ml for part 100 i	units/ml	
	Per Nevada Infusion	Sion OK neparii 5	illi for port – 100 t	units/ini	
NUKSING.	Per Nevaua IIIIusion				
LABS ORDE	RS:	Fax results to:			
PROVIDER	INFORMATION:				
	lame:		1	NPI:	
Physician S	ignature:		[Date: Email:	
Point of Co	ntact:	Pho	ne:		

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

^{**}Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **





	PH: 775-453-0667 Fax: 775-470-8
Patient Name: _	DOB:

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:
☐ Signed provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
☐ Supporting documentation to include past tried and/or failed therapies
☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or
contraindications to conventional therapy:
 ☐ Has the patient had a documented contraindication/intolerance or failed trial of a corticosteroid or immunomodulator? ☐ Yes OR ☐ No If yes, which drug(s)?
 □ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Stelara, Cimzia, infliximab)? □ Yes OR □ No If yes, which drug(s)?
☐ Include labs and/or test results to support diagnosis
☐ If applicable - Last known biological therapy: and last date received: If patient is switching to biologic therapies, please perform a wash out period of weeks prior to starting Entyvio.
☐ Other medical necessity:
Additional REQUIRED Information: ☐ TB screening test completed within 12 months - please include results ☐ Positive OR ☐ Negative

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 \square LFTs - can be drawn with first infusion if not previously completed/available

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