Hy-Vee health INFUSION CARE

ENTYVIO (VEDOLIZUMAB) Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of prescription/medical card(s) (front and back).

Medical Information

J Code: J3380

Diagnosis: ☐ Crohn's disease ICD-10 Code: _____

☐ Ulcerative colitis ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/progress notes, labs and tests supporting primary diagnosis attached

Date of Last TB/CXR: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. Yearly TB screening (*optional*)

Required Lab: Baseline liver enzymes (within 6 months, preferably)

Entyvio Orders

Entyvio

☐ Initial dosing: 300 mg IV at weeks 0, 2 and 6, then every 8 weeks

☐ Maintenance: 300 mg IV every 8 weeks

☐ 300 mg IV every _____ weeks

****Date of Last:** ☐ Remicade ☐ Humira ☐ Stelara ☐ Other: _____ Dose: _____

Additional Orders/Comments:

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ **Physician Name:** _____ **Date:** _____

Phone: _____ **Fax:** _____ **Contact Person:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other: _____

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