

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):
 Primary Diagnosis: _____ Crohn's Disease ICD-10 Code: K50. _____
 _____ Ulcerative Colitis ICD-10 Code: K51. _____
 _____ Other: ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:
 • Clinical MD Notes, labs, test supporting primary diagnosis
 • Previous Drug Therapy History, including therapies trialed and or failed and date of last infusion:
 Remicade Orencia Humira Cimzia Date: _____
 • TB Screening Documentation
 Date of most recent screening: _____

Patient
Weight: _____ lbs.
Height: _____ in.

Infusion Center – Lab Orders (Check order for Infusion Center to manage):
 Obtain liver enzymes at baseline and every six months thereafter

ENTYVIO® (vedolizumab) J Code: J3380

4. Drug Order:
Entyvio 300 mg over thirty (30) minutes via a pump.
 Frequency: _____ # Refills (Recommend 5 refills)
 New Start: Administer on week 0, 2, 6 and then every 8 weeks thereafter
 Maintenance: Administer every eight weeks
Pre-Medication Orders: Acetaminophen 650 mg PO administered 30 min prior to infusion *adjust to patient's needs
 Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
 Dispense as written Substitution permitted
 Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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