

ENTYVIO (Vedolizumab) ORDER FORM

REFERRAL TYPE

- New Referral
 Order Renewal
 Restart
 Frequency Change
 Dosage Change

PREFERRED LOCATION

- | | | |
|--|--|---|
| <input type="checkbox"/> 2730 University Blvd. West Suite 714
Wheaton, MD 20902 | <input type="checkbox"/> 14995 Shady Grove Road Suite 250
Rockville, MD 20850 | <input type="checkbox"/> 5454 Wisconsin Avenue Suite 600
Chevy Chase, MD 20815 |
| <input type="checkbox"/> 18111 Prince Philip Drive Suite 323
Olney, MD 20832 | <input type="checkbox"/> 71 Thomas Johnson Drive
Frederick, MD 21702 | <input type="checkbox"/> 2021 K Street, NW Suite 300
Washington, DC 20006 |

PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight: KG LBS	Phone:

REFERRING PHYSICIAN INFORMATION

Name:	NPI:	
Office Contact Name:	Phone:	Fax:
Address:		

ENTYVIO ORDER

Dosing/Frequency:

- Initial/Reload: 300mg IV at 0, 2, 6 weeks, and then a maintenance dose of every _____ weeks
 Maintenance: 300mg IV every _____ weeks

Diagnosis:

- | | |
|---|--|
| <input type="checkbox"/> K50.00—Crohn's disease of small intestine w/o complications | <input type="checkbox"/> K51.018—Ulcerative (chronic) pancolitis with other complication |
| <input type="checkbox"/> K50.013—Crohn's disease of small intestine with fistula | <input type="checkbox"/> K51.30—Ulcerative (chronic) rectosigmoiditis w/o complications |
| <input type="checkbox"/> K50.10—Crohn's disease of large intestine w/o complications | <input type="checkbox"/> K51.80—Other ulcerative colitis w/o complications |
| <input type="checkbox"/> K50.113—Crohn's disease of large intestine with fistula | <input type="checkbox"/> K51.90—Ulcerative colitis, unspecified, w/o complications |
| <input type="checkbox"/> K50.80—Crohn's disease of both small and large intestine w/o complications | |
| <input type="checkbox"/> K50.90—Crohn's disease, unspecified, w/o complications | |
| <input type="checkbox"/> K51.00—Ulcerative (chronic) pancolitis w/o complications | |

Other Diagnosis: _____ ICD-10 Code (Required): _____

Special Instructions:

Physicians Signature:	Date: _____ <i>(Order is Valid for One Year)</i>
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REQUIRED DOCUMENTATION

Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent labs that include values for:
 - CMP and CBC, TB screening (PPD, QFT Gold or TSpot)
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.