REVITALIZE
INFUSION CENTER

Entyvio®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Crohn's Disease ICD-10 Code: K50._____

☐ Ulcerative Colitis ICD-10 Code: K51._____

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Relevant labs and tests
- Required Information:
  - TB Screening Documentation
  - Documentation of therapies that were previously trialed and failed/discontinued and rationale

Height: _____

Weight: _____

Entyvio ® (vedolizumab) Orders:

☐ New Start: Administer Entyvio® 300 mg IV over thirty minutes on Week 0, 2, 6 and every 8 weeks thereafter for a total of 8 doses

☐ Maintenance Dose:

☐ Administer Entyvio® 300 mg IV over thirty minutes every 8 weeks for a total of 8 doses

☐ Administer Entyvio® 300 mg IV over thirty minutes every ____ weeks for a total of 8 doses

Pre-Medication Orders: Acetaminophen 650 mg PO administered 30 minutes prior to the infusion

☐Other:_____

Lab Orders: ☐ Obtain liver enzymes at baseline and every six months thereafter

☐Other:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form an all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus