

ENTYVIO ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO
REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____ Phone: _____ Email: _____

Height (in): _____ Weight (lb): _____ Referral Status: ☐ New ☐ Updated ☐ Renewal

Infusion/ Injection Information

Primary ICD-10 Code: _____ Primary ICD-10 Description: _____

Other ICD-10 Codes: _____ Other ICD-10 Descriptions: _____

Entyvio (vedolizumab) Dosing Info:

- ☐ Initial: 300mg IV on weeks 0, 2, and 6
☐ Maintenance: 300mg IV every _____ weeks

Required Documentation:

- ☐ Full Patient Chart
☐ Insurance Cards (Front and Back)
☐ Clinical Notes Supporting Diagnosis
☐ List of Current Medications, Conditions,
and Allergies

Premedications:

- ☐ Acetaminophen _____ mg
☐ PO ☐ IV
☐ Cetirizine _____ mg ☐ PO
☐ Diphenhydramine _____ mg
☐ PO ☐ IV
☐ Hydrocortisone _____ mg ☐ IV
☐ Loratadine _____ mg ☐ PO
☐ Methylprednisolone _____ mg ☐ IV
☐ Other: _____ mg
☐ PO ☐ IV

Ordering Provider Information

Practice Name: _____ Practice Phone: _____ Practice Fax: _____

Practice Address: _____ Referral Coordinator Name: _____

Referral Coordinator Email: _____ Referral Coordinator Phone: _____

Ordering Provider: _____ Provider NPI: _____ Specialty: _____

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name

Provider Signature

Date