

## **ENTYVIO (VEDOLIZUMAB)**

Order Form

**PHONE** 515.225.2930 | **FAX** 515.559.2495

Patient Information				Demo	graphics Attached
Patient Name:			DOB:	Phone:	
INSURANCE INFORMATION: Please attach a copy of prescription/medical card(s) (front and back).					
Medical Information					
J Code: J3380	Ulcera	ative colitis	ICD-10 Code:		
Patient Weight:		:	ICD-10 Code:		
Allergies:					
Date of Last TB/CXR:	es, labs and tests support  Copy of be drawn by: Infusion	documentation	attached		
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					
Mainten 300 mg	osing: 300 mg IV at weeks ance: 300 mg IV every 8 v IV every week micade Humira mments:	veeks			)ose:
Physician Information					
By signing this form and utilizing our services, you are authorizing <i>Hy-Vee Health</i> 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 I		Physician Na	me: Date:		
Phone:	Fax:	Contact Pe	rson:		
Service Areas					
Des Moines, IA Phoenix, AZ	West Des Moines, IA Other:	Chicago,	IL Omaha,	NE Buffalo, N	Y Dallas, TX

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