ENTYVIO® (Vedolizumab)
Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

10750 W. Howard Avenue
Greenfield, WI 53228
Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ D/C Infusions

Diagnosis and ICD 10 Code	
☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Other Diagnosis:	ICD 10 Code:

Supporting Documentation	
☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests including baseline liver function test
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders

☐ Initial Dose: ENTIVYO® 300 mg IV at week 0, 2, 6 then every 8 weeks
☐ Maintenance Dose: ENTIVYO® 300 mg IV every 8 weeks

Premedication

☐ Acetaminophen 650mg PO prior to Entyvio Infusion
☐ Diphenhydramine 25mg PO prior to Entyvio Infusion
☐ Cetirizine 10mg PO or IV
☐ Methylprednisolone IV _____mg

Notes (Additional Info)

Adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information		
Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

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