

ENTYVIO® (Vedolizumab)
Order/Referral Form



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Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information			
Patient Name:	Patient DOB:		
Referral Status			
<input type="checkbox"/> New Referral	<input type="checkbox"/> Restart/Continuation	<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> D/C Infusions
Diagnosis and ICD 10 Code			
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90		
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90		
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:		
Supporting Documentation			
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis		
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests including baseline liver function test		
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Current Medication List		
Medication Orders			
<input type="checkbox"/> Initial Dose: ENTIVYO® 300 mg IV at week 0, 2, 6 then every 8 weeks			
<input type="checkbox"/> Maintenance Dose: ENTIVYO® 300 mg IV every 8 weeks			
Premedication			
<input type="checkbox"/> Acetaminophen 650mg PO prior to Entyvio Infusion			
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Entyvio Infusion			
<input type="checkbox"/> Cetirizine 10mg PO or IV			
<input type="checkbox"/> 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.			

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.