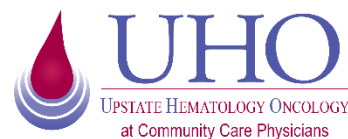


# Entyvio



Ph: 518-836-3030 | Fax: 518-836-3020

Date: \_\_\_\_\_

**Please include the following to expedite the order**

**Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Viral Hepatitis Results, TB Results**

## PATIENT INFORMATION

## PRESCRIBER INFORMATION

Patient Name: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Allergies: \_\_\_\_\_

Office Address: \_\_\_\_\_

Weight: \_\_\_\_\_ ○ lbs ○ kg Height: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Contact Email: \_\_\_\_\_

ICD 10: \_\_\_\_\_

☐ Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

## PREMEDS

☐ No Premeds

Benadryl:                      ☐ PO   ☐ IV                      ☐ 25 mg   ☐ 50 mg

Acetaminophen:           ☐ PO                      ☐ 650 mg   ☐ Other: \_\_\_\_\_

Methylprednisolone:   ☐ IV                      ☐ \_\_\_\_\_ mg

Other: \_\_\_\_\_

☐ You authorize UHO to utilize the hypersensitivity protocol established by UHO.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## ENTYVIO DOSAGE

Date of Last Treatment, if Continuation: \_\_\_\_\_

Route: ☐ IV

☐ Loading 300 mg in 250 mL 0.9 % NaCl at week 0, 2, 6 and then q8weeks

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☐ Maintenance 300 mg in 250 mL 0.9 % NaCl every 8 weeks

☐ Other: \_\_\_\_\_

Refills: ☐ 3 months ☐ 6 months

(if not indicated order will expire 6 months from date signed)

***To ensure that a Brand name product be dispensed, the prescriber must handwrite “Brand Medically Necessary” on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.***

## LAB ORDERS

☐ No Labs

List: \_\_\_\_\_

Frequency: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_