Lincoln Medical Center
OUTPATIENT INFUSION CENTER
Phone: 931-438-1100
Fax: 1-931-438-1219

ENTYVIO ORDER FORM

Patient name: ______________________ DOB: ____________ Sex :( ) Male ( ) Female
SSN:______________ HT: ________ WT: ________ Allergies:______________________
Street Address______________________ City/State/Zip ______________________
Home Phone #: ______________ Work #: ______________ Cell #: ______________

Insurance Information:

Primary Insurance Name ______________________ Policy ID #: ______________
Secondary Insurance Name______________________ Policy ID #:______________

Physician Information:

Physician's Name:______________ Referral Contact Name: ______________ Phone: __________
Address:______________________City/State/Zip______________________
DEA#:______________ NPI #:______________ Fax #: ______________
State License #: ______________

Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description)______________________
Date of Diagnosis: ______________

Pertinent medical history

TB test performed? ☐ Yes ☐ No Results:______________ Patient diagnosed with Congestive Heart Failure? ☐ Yes ☐ No
Liver function test normal? ☐ Yes ☐ No Comments______________________
Does the patient have venous access? ☐ Yes ☐No If Yes, what type? ______________________
Patient previously treated with Remicade? ☐ Yes ☐ No Date: ______________
Patient had Hep-B antigen surface antibody test? ☐ Yes ☐ No Date: ______________

Orders: ENTYVIO® (VEDOLIZUMAB) 300mg IV

*****Normal Saline will be used to clear all lines. All MEDIPORTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. *****

☐ Do not administer Heparin to this patient. ☐ Insert PIV ☐ Insert PICC

Dose: Entyvio 300mg IV in NS 0.9% 250ml, Infuse over 30 minutes then flush line with 30mL of NS

Frequency:

☐ Loading doses: Infusion at 0, 2, and 6 weeks, then once every __________ weeks

☐ Once every __________weeks

Labs: ____

Premedication:
☐ Benadryl: ________mg ☐ PO ☐ IV X1 dose
☐ Oxygen: ____
Other:____

Physician's Signature ______________________**Date**______________ **Time:** __________

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.