LivWell INFUSIONS

Entyvio Infusion Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ K51.90 Ulcerative Colitis

◯ K50.90 Crohn's Disease

◯ Other: _____

ICD-10 _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

◯ Insurance Cards

ENTYVIO ORDER

Entyvio Dose: ◯ 300 mg

Patients weight (kg): _____

Frequency:

Initial Dose: ◯ 0, 2 and 6 weeks

Maintenance dose: ◯ Every 8 weeks

Premeds:

☐ Benadryl (Diphenhydramine) ◯ Oral 25mg ◯ Oral 50mg ◯ IV 50mg

☐ Acetaminophen (Tylenol) ◯ 500 mg

Date of last Entyvio Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____