PARAGON INFUSION CENTERS

ENTYVIO (VEDOLIZUMAB) INFUSION ORDERS

PATIENT INFORMATION

☑ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

J Code: J3380 Diagnosis: ☐ Crohn's Disease ICD-10 Code: _____

☐ Ulcerative Colitis ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Date of last TB/CXR: _____ ☐ Copy of documentation attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(optional)*

Required Lab: Baseline Liver Enzymes (within 6 months, preferably)

ENTYVIO ORDERS

Entyvio ☐ Initial Dosing: 300mg IV at 0, 2, 6 then every 8 weeks

☐ Maintenance: 300mg IV every 8 weeks

☐ 300mg IV every _____ weeks

****Date of Last:** ☐ Remicade ☐ Humira ☐ Stelara ☐ Other: _____ Dose: _____

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc.and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta