ENTYVIO (VEDOLIZUMAB) Referral Order Form

FAX (855) 891-2191

Effective: 10/2016

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

_____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

ENTYVIO MEDICATION ORDERS

☐ Initial/Reload Dosing: **300** mg IV on day 0, 2 weeks, 6 weeks then every ____ weeks.

☐ Maintenance Dosing: **300** mg IV every ____ weeks.

INDICATION/DIAGNOSIS

☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

STANDING LAB ORDERS

Labs to be drawn by:
☐ Referring Physician
☐ Infusion Center

Orders:
☐ CMP ☐ CBC ☐ CRP
☐ ESRP ☐ HFP ☐ UA

Frequency:
☐ Every Infusion
☐ Other _____

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ PPD Results (w/in 6 months) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months ☐ Chest X-ray (if indicated)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY