

# Entyvio Order Form

*Pre-filled order form for Entyvio (vedolizumab) — Gut-selective biologic for IBD*

**REFERRING PROVIDER**

<b>PROVIDER NAME</b>	<b>NPI</b>	<b>DEA (IF CONTROLLED)</b>	<b>SPECIALTY</b>
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<b>PRACTICE / CLINIC NAME</b>	<b>OFFICE PHONE</b>	<b>OFFICE FAX</b>
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<b>OFFICE CONTACT NAME</b>	<b>CONTACT PHONE</b>	<b>CONTACT EMAIL</b>
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**PATIENT INFORMATION**

<b>PATIENT LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>
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<b>DATE OF BIRTH</b>	<b>SEX</b>	<b>PATIENT PHONE</b>	<b>BEST TIME TO CONTACT</b>
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<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
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**INSURANCE**

<b>PRIMARY INSURANCE</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
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<b>SECONDARY INSURANCE (IF ANY)</b>	<b>MEMBER ID</b>	<b>GROUP #</b>
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**DIAGNOSIS & CLINICAL JUSTIFICATION**

<b>PRIMARY DIAGNOSIS</b>	<b>ICD-10 CODE</b>
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<b>SECONDARY DIAGNOSIS (IF APPLICABLE)</b>	<b>ICD-10 CODE</b>
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**Common indications for this medication:** *Ulcerative colitis, Crohn's disease*

**BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY**

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**PRIOR THERAPIES TRIED AND OUTCOME**


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**ENTYVIO REFERENCE**

**Generic name:** vedolizumab  
**Specialty:** Gastroenterology  
**Typical infusion time:** About 30 minutes  
**Typical schedule:** Loading at weeks 0, 2, 6 — then every 8 weeks

**MEDICATION ORDER**

MEDICATION (DEFAULT: ENTYVIO)	GENERIC / ALT (VEDOLIZUMAB)	STRENGTH / FORMULATION
DOSE	FREQUENCY (TYPICAL: LOADING AT WEEKS 0, 2, 6 — THEN EVERY 8 WEEKS)	DURATION (TYPICAL: ABOUT 30 MINUTES)
ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)
		BIOSIMILAR ACCEPTABLE (Y/N)

**REQUIRED LABS & MONITORING**

Check all labs the prescriber requires Arbor to verify before each infusion:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> CBC w/ differential           | <input type="checkbox"/> CMP                             | <input type="checkbox"/> Liver function panel   |
| <input type="checkbox"/> Hepatitis B/C panel           | <input type="checkbox"/> TB screen (T-SPOT or QFT)       | <input type="checkbox"/> Pregnancy test (urine) |
| <input type="checkbox"/> Iron studies (ferritin, TSAT) | <input type="checkbox"/> Vitamin levels (B12, D, folate) | <input type="checkbox"/> Other (specify below)  |

**OTHER LABS / MONITORING REQUIREMENTS**


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**PRESCRIBER SIGNATURE**

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

<b>PRESCRIBER SIGNATURE</b>	<b>PRINTED NAME</b>	<b>DATE</b>
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*Form code: ARB-ORDER-ENTYVIO · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com*