**vedolizumab (Entyvio®) Order Form** **FAX to 1 (888) 797-4008**

| PATIENT INFORMATION | | |
|---|---|---|
| Patient Name: | | DOB: |
| Address: | | |
| City: | State: | Zip code: |
| Patient's phone number: | | |
| Is patient a Wayne Health patient registered in athena? ☐ Yes ☐ No | | |

| | | |
|---|---|---|
| Order date: | Weight: kg lbs | Height: m in |
| Drug allergies: ☐NKDA ☐YES. Please specify. | | |
| ICD-10 diagnosis: | | |

| LABORATORY DATA | | |
|---|---|---|
| CBC: | BMP/CMP: | Serology: |
| Other: | | |

| vedolizumab (Entyvio®) | | |
|---|---|---|
| ☐ 300 mg on wk 0, 2 and 6 | ☐ 300 mg q _____ wks | Refills: |

| ORDERING PHYSICIAN INFORMATION | |
|---|---|
| Name: | NPI: |
| Address: | |
| Phone number: | Fax number: |
| Physician signature: | Date: |

*To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.*