

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (____)____-____ Fax: (____)____-____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (____)____-____

Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

_____ Ulcerative Colitis _____ (other)
 _____ Crohn's Disease

Pre-Medication

Tylenol 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10 mg PO Diphenhydramine 25mg IVP
 _____ (other)

Entyvio Intravenous Order

DOSAGE Patient Weight

300mg IV Infuse per protocol _____ lbs
_____ kg

FREQUENCY

Induction Dose at weeks 0, 2, and 6, then every ___ weeks
 Maintenance Dose every ___ weeks

NOTES

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____