ENTYVIO (vedolizumab) Referral Order Form

Fax 888.615.1445

Precisionhc
clinically advanced infusion care
WWW.PRECISIONHC.COM
Phone: 615.367.1444 FAX: 888.615.1445

☐ New Referral ☐ Restart ☐ Medication/ Order Change (New Order Required) ☐ Benefits Verification Only ☐ Refill / Renewal

Precision Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

ENTYVIO MEDICATION ORDERS

☐ INDUCTION DOSE: 300 mg IV over 30 minutes @ 0, 2 & 6 weeks

☐ MAINTENANCE DOSE: 300 mg IV every 8 weeks

☐ OTHER MAINTENANCE DOSE (please specify) 300 mg IV every _____ weeks

INDICATION/DIAGNOSIS(required)

***ICD-10 Code/Description** _____

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Premedications: (If desired, please choose:)

☐ Diphenhydramine ☐ 25mg PO ☐ 50mg PO or ☐ 25mg IV ☐ 50mg IV

☐ Acetaminophen 500 mg PO

☐ Other: _____

_____ _____

Referring Physician's Signature Date

Refills x 1 year (unless otherwise specified)

May use Precision Allergy Reaction Protocol

LAB ORDERS FOR PRECISION NURSING TO DRAW (please specify)

Orders: _____

Frequency: _____

NOTES (ADDITIONAL INFO OR ORDERS)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet ☐ Report Allergies

ATTACH REQUIRED LAB RESULTS (For New Referrals Only)

☐ TB test results OR ☐ Please have Precision do TB skin test or QFG (Precision may proceed with infusion prior to known results)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE AND TIME: _____

FOR OFFICE USE ONLY

11.2019