

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



ENTYVIO ORDER FORM

Patient Name: _____ ICD-10 Code: _____	Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Date of Birth: _____ Allergies: _____	
Weight: _____ lbs OR _____ kg	

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Entyvio	<input type="checkbox"/> Initiation: Administer Entyvio 300mg IV over 30 minutes at weeks 0 and 2.	Refills for one year from date of signature unless indicated below. _____ Refills	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: <input checked="" type="checkbox"/> Negative TB result and date: _____
	<input type="checkbox"/> Maintenance: <input type="checkbox"/> CD/UC: Week 6 and thereafter administer Entyvio 300mg IV over 30 minutes every 8 weeks per protocol. <input type="checkbox"/> CD/UC: Week 6 and thereafter administer Entyvio 300mg IV over 30 minutes every _____ weeks per protocol. TwelveStone does not have access to the Entyvio Pen for subcutaneous dosing		

PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	IV <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
--	---

LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none">• History & Physical, Last Office Visit Note• Patient Demographics and Insurance Information• Medication List• Recent Lab Work
--	---

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature

Date