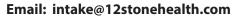
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ENTYVIO ORDER FORM							
Date:		ICD-10 Code:			E New Otest	Therapy Status	
Patient Name:		Allergies:			☐ New Start		
Date of Birth:		Weight:Ibs	OR	kg	Continuing Thera	py: Dose:	
PROVIDER INFORMATION							
Ordering Provider:				Provider Fax:			
Provider NPI:		Provider Address:					
Provider Phone:							
MEDICATION ORDER							
Entyvio	 □ Initation: Administer Entyvio 300mg IV over 30 minutes at 0 and 2. □ Maintenance: □ CD/UC: Week 6 and thereafter administer Entyvio 30 over 30 minutes every 8 weeks per protocol. □ CD/UC: Week 6 and thereafter administer Entyvio 30 over 30 minutes every weeks per protocol. 		ntyvio 300mg I\ ntyvio 300mg I\	Refills date of inc	for one year from f signature unless dicated below.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: V Negative TB result and date:	
PRE-MEDICATIONS							
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:				□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg			
LAB ORDERS (please indicate any labs to be drawn and frequency)			uency)	OTHER REQUIRED DOCUMENTATION			
Surveillance lab ordering and monitoring is the responsibility of the prescriber			to 80 • His • Pat • Mee	 (Please fax this signed order form, along with the following documents to 800-223-4063) 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 s					my signature for prior auth		
Dispense as	Written:		Subs	itution Allo	owed:		
Prescriber S	ignature	Date	Pres	criber Sigr	nature	 Date	