

Entyvio® Enrollment Form

 Fax Referral To: 877-277-9155
 Phone: 877-828-3940
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 www.infucarerx.health

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____	Ship To: _____	Patient _____	MD Office _____	Other: _____	
PATIENT INFORMATION		PRESCRIBER INFORMATION			
Patient Name: _____	Prescriber Name: _____				
Address: _____	Address: _____				
City, State, Zip: _____	City, State, Zip: _____				
Home Phone: _____	Phone: _____				
Cell Phone: _____	Fax: _____				
Date of Birth: _____	Gender: _____	DEA #: _____	NPI #: _____		
Emergency Contact: _____	Phone: _____	Contact Person: _____			
INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)					
Primary Insurance: _____	ID: _____	Group: _____			
Secondary Insurance: _____	ID: _____	Group: _____			
Prescription Card: _____	ID: _____	BIN: _____	PCN: _____		
To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:					
PATIENT DIAGNOSIS/CLINICAL INFORMATION					
K50.00 Crohn's Disease	TB/PPD Test:	Positive	Negative	Date Read: _____	
K51.90 Ulcerative Colitis	Weight:	kg	lbs	Height: _____ cm in %BSA: _____	
Other: _____	Allergies:	NKDA			
Prior Medication Failed: _____	Injection Training/Home Health RN visit is necessary: Yes _____ No _____				
Length of Treatment: _____	Site of Care:	Home	MD Office	Other: _____	
Reason for Discontinuation: _____					
PRESCRIPTION INFORMATION					
Medication:	Dose/Strength:	Directions:			Refills:
Entyvio®	300mg vial	Initial: Infuse 300mg IV over 30 minutes at week 0, week 2, and week 6 (Quantity: 3) Maintenance: Infuse 300mg IV over 30 minutes every _____ weeks (Quantity: 1)			
Premedications & Other Medications:		Acetaminophen: _____ mg PO prior to infusion	Flush Protocol:		
► Infusion supplies as per protocol		Diphenhydramine: _____ mg PO IV	► NaCl 0.9% 10ml		
► Anaphylaxis Kit as per protocol		250ml 0.9% NaCl for hydration	► Before and after infusion		
		Other: _____	► Flush the administration set with 30 mL of NaCl 0.9% after the infusion is complete		
ADDITIONAL COMMENTS					

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature: _____ **Date:** _____

 The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by faxing back to the originator.