

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION			
Name:		DOB:	
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis		ICD 10 Code: K51.90	
<input type="checkbox"/> Moderate to Severe Crohn's Disease		ICD 10 Code: K50.90	
<input type="checkbox"/> Other: _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> TB Test Results (must be within 1 year)		<input type="checkbox"/> Baseline liver function tests <input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Vedolizumab level and antibody test results (if changing dose or frequency)	
*Patient may be required to submit a pregnancy test prior to treatment			
List Tried & Failed Therapies, including duration of treatment:			
1)			
2)			
3)			
MEDICATION ORDERS			
Dosing Wt for Calculations		Ht:	Wt: BMI:
Initial Dosing	<input type="checkbox"/> J3380 Entyvio 300mg IV at week 0, 2, 6 then every 8 weeks		
Maintenance Dosing	<input type="checkbox"/> J3380 Entyvio 300mg IV every 8 weeks		
Alternative Dosing	<input type="checkbox"/> J3380 Entyvio 300mg IV every _____ weeks		
Duration	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses
PREMEDICATIONS			
<input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Diphenhydramine 25mg IV Push or PO <input type="checkbox"/> Methylprednisolone 125mg Slow IV Push <input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS / INFORMATION			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:	Office Fax:	Office Email:	
Prescriber Signature:	Date:	Time:	

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at: SBL Infusion Center
 Ph. 217-258-4150
 217-342-7500
 Fax Completed Form and all documentation to: Fax 217-342-7499