Edward-Elmhurst HEALTH | Healthy Driven

Edward Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/527-3788 Fax: 630/548-6617

24600 West 127th Street; Plainfield, IL 60585
Phone: 630/527-3788 Fax: 630/548-6617

Entyvio Infusion Therapy Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____
(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Diagnosis (ICD 10 Required): _____ **Weight (lbs/kg):** _____

Annual TB Testing Required (Date): _____ **Result Neg:** ☐ **Yes** ☐ **No**

Is this their first dose? Yes: _____ **No:** _____

Dose: 300 **mg IVPB over 30 minutes in NS 250ml**

Visit Frequency: Given at weeks 0, 2, 6, and then every 8 weeks

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Edward Hospital NPI:** 1427069632

Physician Name (Please Print)	Office Phone	Fax Number

Revision/Review Date: 02/23/18