

Patient Information

Name: _____ DOB: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Weight: _____ ☐ lbs ☐ kgs
Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Medication List | Most Recent Labs
Tried and Failed Therapies (including duration) | Negative TB Results

Primary Diagnosis

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☒ Per infusion clinic protocol: No recommended standard pre-meds for Entyvio
☐ Provider Prescribed: _____

Primary Medication Order

☐ Entyvio 300mg IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Entyvio 300mg IV every _____ weeks.
☐ Other: _____

*If using SubQ maintenance dosing (must have received 2 IV doses to be eligible):

☐ Infusion clinic to coordinate with Specialty Pharmacy: Entyvio 108mg SubQ every 2 weeks
☐ Provider to coordinate with Specialty Pharmacy

First Dose: ☐ Yes ☐ No ☒ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☒ Start PIV/ACCESS CVC ☒ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☒ Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____
Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature

Date