Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

ThrIVewell™ INFUSION

Mission Medical

Office: 212-803-3339 Fax : 646-768-8600

(vedolizumab)

ENTYVIO

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Ulcerative Colitis
☐ _____ Crohn's Disease
☐ _____ _____
☐ _____ _____

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

SPECIAL INSTRUCTIONS

ENTYVIO ORDERS

DOSE:

☐ 300mg IV
☐ Other_____

FREQUENCY

☐ Dose at weeks 0,2, and 6, then every 8 weeks
☐ Dose every_____

ROUTE

☐ IV

TOTAL DOSES:

☐ 1 yr _____ ☐ Other_____ ☐ Refill_____
Route: ☐ SQ ☐ IV

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____