RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Entyvio Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Entyvio Medication Orders

Dosage

- _____ 300mg IV initiation doses at 0,2 and 6 weeks for the first 3 doses
- _____ 300mg IV every 8 weeks
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Ulcerative colitis ____ Crohn's disease _____Other _____
- ICD 10 code _____

Pre-Medication	Refills
• Tylenol _____mg • Benadryl _____ mg __IV or ___PO • Solumedrol IV Push _____ mg • Other _____	• Zero _____ • Treatments for 1 year _____ • Other _____

Required Documentation

• Insurance Cards (Front and Back) • Patient Demographics • Recent Progress Notes
• Lab Results – CMP, CBC, TB screening prior to initiation

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**