PARAGON HEALTHCARE

A Carelon Company

ENTYVIO (VEDOLIZUMAB) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Entyvio (vedolizumab)	☐ 300mg IV at 0, 2, 6, then every 8 weeks ☐ 300mg IV at 0 and 2 weeks ☐ 300mg IV every 8 weeks ☐ 300mg IV every _____ weeks ☐ Other: _____	☐ x 1 year ☐ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

☐ TB QFT Screening yearly (optional)

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR ENTYVIO (VEDOLIZUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a corticosteroid or immunomodulator? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Stelara, Cimzia, infliximab)? ☐ Yes ☐ No
  If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis

☐ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Entyvio.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **TB screening test (completed within 12 months for new start) - attach results**

- ☐ **Positive** ☐ **Negative**

☐ **LFTs - can be drawn with first infusion if not available**

*If TB results are positive - please provide documentation of treatment or medical clearance, and a negative CXR