BioTek reMEDys®

# ENTYVIO®

Please Fax Completed Form To: 800-783-9146

## PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________ Alt. Phone: ______________
Email: ______________ SS#: ______________
Gender: ☐ M ☐ F Weight: ______(lbs) Ht: __________
Allergies: ______________________

## PRESCRIBER INFORMATION

Prescriber Name: ______________________
State License: ______________________
NPI #: ______________ DEA: ______________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________ Fax: ______________
Office Contact: ______________ Phone: __________

## INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ______________________
City, State, Zip: ______________________
Plan #: ______________________
Group #: ______________________
Phone: ______________________

RX Card (PBM): ______________________
BIN: ______________ PCN: ______________
City, State, Zip: ______________________
Group #: ______________________
Phone: ______________________

## CLINICAL INFORMATION

☐ Moderately to severe active Ulcerative Colitis: ICD-10 Code (s) ______________

☐ Moderately to severe active Chron's Disease: ICD-10 Code (s) ______________

☐ Other Diagnosis: ICD-10 Code (s) ______________

## (DRUG NAME) ORDERS – this section may not be needed)

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: __________ Date of Last Infusion/Injection: __________

| Medication | Directions | Quantity/Refills (This prescription is valid for 12 months from date of signature unless otherwise noted) |
|---|---|---|
| ☐ Entyvio® Induction Dosing | ☐ 300mg infused over approximately 30 minutes at zero, two and six weeks | |
| ☐ Entyvio® Maintenance Dosing | ☐ 300mg infused over approximately 30 minutes every 8 weeks following induction dosing | |
| ☐ Other Dosing: | | |

Pre-medication: ______________________________________

## SIGNATURE

X______________________________________ Date: ______________

Prescriber Signature

**CONFIDENTIALITY STATEMENT:** This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.