Endeavor Health SM

Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Entyvio Infusion Therapy Orders

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____
(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Diagnosis (ICD 10 Required): _____ **Weight (lbs/kg):** _____

Annual TB Testing (Date): _____ **Result Neg:** ☐ **Yes** ☐ **No**
☐ **No TB test per provider**

Is this their first dose? Yes: _____ **No:** _____

Dose: **300** **mg** **IVPB over 30 minutes in NS 250ml**

Visit Frequency: **Given at weeks 0, 2, 6, and then every 8 weeks**

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Swedish Hospital NPI:** **1831151257**

_____ _____ _____
Physician Name (Please Print) **Office Phone** **Fax Number**

Revision/Review Date: 12/2024