LUX INFUSION

Treatment Enrollment Form

Toll Free Phone: 1-866-665-3244 | Toll Free Fax:1-844-461-3244 | Email: infusions@luxinfusion.com

Patient Information

Patient Name: _____ SSN#: _____ Gender: ☐ Male ☐ Female

DOB: _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ E-mail Address: _____

Emergency/guardian Contact: _____ Emergency/guardian Phone: _____

Insurance Information – Please attach front and back of patient's insurance cards

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: _____

Prescription Card: ☐ Yes ☐ No _____ ID#: _____

PCP Referral Required: ☐ Yes ☐ No PCP Name: _____

Prescriber Information

Prescriber's Name: _____ Hospital/Group: _____

Street Address: _____ Office Phone: _____

City, State, Zip: _____ Office Fax: _____

E-mail Address: _____ Office Contact Person: _____

NPI#: _____ Tax ID#: _____ State License#: _____

Prior Authorization Information – For us to complete PAs for you, please send the following:

- ○ Patient demographic page
- ○ Patient SSN
- ○ Most recent H&P
- ○ Most recent labs
- ○ Copy of any/all insurance cards on file, both medical and pharmacy

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Revised: March 2026

Patient Information

Patient Name: _____ DOB: _____

Entyvio

Infusion Order Form

Clinical Information

Primary ICD-10 Code: _____ Weight: _____ (kg ◯ / lbs ◯) Height: _____ (cm ◯ / in ◯)

Patient previously treated for this condition: ☐ Yes ☐ No Patient currently on treatment: ☐ Yes ☐ No

Known Allergies: _____

All ICD-10 codes for any/all related diagnosis (if not listed in H&P): _____

Pre-medication Information

✓ **Acetaminophen 325mg, can be repeated x1, not to exceed 650mg, PRN**

✓ **Diphenhydramine 25mg PO or IV, PRN**

☐ _____

✓ **Methylprednisolone 125mg IV, PRN**

✓ **Ondansetron 4mg IV, PRN**

☐ _____

Medication Information

Medication — Note: PFS is abbreviation for Prefilled Syringes	Directions/Frequency — IV Access Type: ☐ Peripheral ☐ PICC ☐ Port
Entyvio (vedolizumab) ☐ 300mg IV at weeks 0, 2, and 6, then every 8 weeks ☐ 300mg IV every ____ weeks	☐ **Treatment x 12 months unless otherwise indicated below** ☐ **Treatment length x _____ month(s) or _____ weeks, frequency at every _____ week(s) or _____ month(s)**

Laboratory Orders

☐ **CBC** ☐ **Before each infusion** ☐ **Frequency:** _____

☐ **CMP** ☐ **Before each infusion** ☐ **Frequency:** _____

☐ **CRP** ☐ **Before each infusion** ☐ **Frequency:** _____

☐ **Other:** _____

Notes

✓ **In event of infusion reaction, follow Adverse Reaction Protocols for treatment.**

☐ **Infusion reaction special orders:** _____

Prescriber Information

Prescriber Name: _____ Prescriber Phone: _____

By signing below, I certify that the above therapy is medically necessary, and I authorize treatment.

_____ _____

Substitution allowed Dispense as written

Date: _____ Date: _____

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