Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Entyvio Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)-228-9798 Attn: Idyllic Infusion Coordinator

Is this a Continuation of Care or a new start to the medication?

- ☐ Continuation of Care (Provide documentation of last administration)
- ☐ New Rx

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	**Name: NPI: Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s)	Include copies of front and back.
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☐ Hamilton ☐ Galloway

Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Name (last, first) _____DOB: _____

Diagnosis:
☐K50.90 Ulcerative colitis
☐ K50.9 Crohn's disease (specific ICD10)

The following information is required for authorization for Entyvio:

- Proof of patient's negative latent TB test. If the test is positive, proof that the patient has begun therapy for latent TB.
- Is the patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy?
    - If yes, circle all that apply. They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Please provide documented failure, contraindication, or ineffective response at maximum tolerated doses to a minimum (3) month trial on previous therapy with a TNF modifier such as Humira, Simponi, or infliximab (Avsola, Inflectra, Remicade or Renflexis).
- Please include all relevant scans, tests, labs, notes to support decision to begin treatment.

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- *-Please notify our office if medication will be discontinued.*

❒ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____