



Vedolizumab (Entyvio)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

Send patient demographics/insurance, clinical notes, and test results with orders

Diagnosis Code/Description for treatment: _____

- ☐ Adult Crohn Disease
☐ Adult Ulcerative Colitis

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port

☒ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Other: _____

Premedication

- ☐ Diphenhydramine (Benadryl) 25 MG IV PUSH ONCE
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE

Infusion – Vedolizumab (Entyvio) [J3380 : 1 MG = 1 unit]

Initial Dosing – 3 doses

- ☒ Vedolizumab (Entyvio) 300 MG in 250 mL of 0.9% Normal Saline Solution INTRAVENOUS ONCE over 30 minutes.
Flush with 30 mL of normal saline after each infusion.

Date of Service: First Dose (_____) next initial dose 2 weeks after first initial dose, then last initial dose 6 weeks after first initial dose, then 8 weeks after last initial dose begin maintenance dose.

Maintenance Dose – Starts 8 weeks after LAST initial dose given.

- ☒ Vedolizumab (Entyvio) 300 MG in 250 mL of 0.9% Normal Saline Solution INTRAVENOUS ONCE over 30 minutes
EVERY 8 WEEKS, flush with 30 mL of normal saline after each infusion.

Infusion Reaction

- ☒ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

- ☒ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE: _____
10622512

TIME: _____

PHYSICIAN'S SIGNATURE