

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: _____

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PHYSICIAN'S SIGNATURE

DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES