| VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM   |   |  |                                 |             |   |   |            |  |
|--|---|--|---------------------------------|-------------|---|---|------------|--|
| Patient Name:  |   |  | Date of Birth:                  |             |   |   |            |  |
| Address:   |   |  |                                 |             |   |   |            |  |
| Phone:   | ŀ   | leight:  |                                 | ☐ inches [  | □ cm  | Weight:                                     | □ lbs □ kg |  |
| Clinical Information   |   |  |                                 |             |   |   |            |  |
| Primary Diagnosis Description:   |   |  | ICD-10 Code:                    |             |   |   |            |  |
| Is this the first dose?  |   |  |                                 |             |   |   |            |  |
| Vedolizumab (Entyvio®) Prescription  Vedolizumab (Entyvio®) refill as directed x 1 year. Please select one of the options below:   |   |  |                                 |             |   |   |            |  |
|  | _   | <u> </u>   |                                 |             | T   |   |            |  |
| ☐ Option 1:  Induction Infuse 300 mg IV over at least 30   | _   | Option 2: Infuse Entyvio 300mg IV over at least 30 |                                 | at least 20 | Option 3:   |   |            |  |
| minutes on Weeks <b>0, 2, 6</b>  |   | at weeks <b>0, 2, 6</b>                            |                                 | at least 30 | Infuse Entyvio 300mg IV over at least 30 minutes at weeks <b>0</b> , <b>2</b> |   |            |  |
| Maintenance Infuse 300 mg IV over at least 30  | aintenance Infuse 300 mg IV over at least 30 Inject Entyvio |  | o 108mg <b>SUBQ</b> at week 14, |             |   | Inject Entyvio 108mg <b>SUBQ</b> at week 6, |            |  |
| minutes every 8 weeks thereafter   | then every 2  | every 2 weeks thereafter                           |                                 | •           | then every 2 weeks thereafter   |   |            |  |
| ☐ Other:   |   |  |                                 |             |   |   |            |  |
| For IV doses, quantity sufficient of Entyvio® 300mg vials will be dispensed to the patient to complete the prescribed treatment plan. In addition, after each infusion   |   |  |                                 |             |   |   |            |  |
| the IV tubing will be flushed with NS 30ml using a 50ml bag.   |   |  |                                 |             |   |   |            |  |
| For SubQ doses, quantity sufficient of Entyvio® 108mg Prefilled Pens will be dispensed to fulfill prescribed treatment plan.  Ancillary Orders   |   |  |                                 |             |   |   |            |  |
| Anaphylaxis Kit  |   |  |                                 |             |   |   |            |  |
| If this is a 1 <sup>st</sup> infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 <sup>st</sup> dose?   |   |  |                                 |             |   |   |            |  |
| ☐ Yes ☐ No   |   |  |                                 |             |   |   |            |  |
| Dosage: • Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.  |   |  |                                 |             |   |   |            |  |
| <ul> <li>Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> </ul>  |   |  |                                 |             |   |   |            |  |
| <ul> <li>0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li> </ul>   |   |  |                                 |             |   |   |            |  |
| Medication Orders  |   |  |                                 |             |   |   |            |  |
| Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.   |   |  |                                 |             |   |   |            |  |
| Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.   |   |  |                                 |             |   |   |            |  |
| ☐ Methylprednisolone Sodium Succinate 40 mg IV push 20 minutes prior to infusion.  |   |  |                                 |             |   |   |            |  |
| Other:   |   |  |                                 |             |   |   |            |  |
| IV Flush Orders  Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.   |   |  |                                 |             |   |   |            |  |
| Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL)  |   |  |                                 |             |   |   |            |  |
| 3 to 5 mL post-useFor maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.   |   |  |                                 |             |   |   |            |  |
| Lab Orders  ☐ No labs ordered at this time.  |   |  |                                 |             |   |   |            |  |
| ☐ Other:   |   |  |                                 |             |   |   |            |  |
| Skilled nurse to assess and administer and/or teach self-administration where appropriate via (IV/SubQ) access device as indicated above. Nurse  |   |  |                                 |             |   |   |            |  |
| will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.  I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.  |   |  |                                 |             |   |   |            |  |
|  |   |  |                                 |             |   |   |            |  |
| Prescriber Signature:  Prescriber Information  Date:   |   |  |                                 |             |   |   |            |  |
| Prescriber Name:   | Prescri   | Phone:   | uon                             |             | F   | ax:   |            |  |
| Address:   |   |  |                                 |             |   | <del></del>                                 |            |  |
| City, State: Zip:  |   | NPI: Office Contact:                               |                                 |             |   |   |            |  |
| Fax completed form, insurance information, and clinical documentation to:  |   |  |                                 |             |   |   |            |  |
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