VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose? ☐ **YES** – Date of first dose: _____ ☐ **NO** – Date of next dose due: _____

Vedolizumab (Entyvio®) Prescription

Vedolizumab (Entyvio®) refill as directed x 1 year. Please select one of the options below:

	☐ **Option 1:**	☐ **Option 2:**	☐ **Option 3:**
Induction	Infuse 300 mg **IV** over at least 30 minutes on Weeks **0, 2, 6**	Infuse Entyvio 300mg **IV** over at least 30 minutes at weeks **0, 2, 6**	Infuse Entyvio 300mg **IV** over at least 30 minutes at weeks **0, 2**
Maintenance	Infuse 300 mg **IV** over at least 30 minutes every 8 weeks thereafter	Inject Entyvio 108mg **SUBQ** at week 14, then every 2 weeks thereafter	Inject Entyvio 108mg **SUBQ** at week 6, 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 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st 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.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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-use. For 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: **Date:**

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

