

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:

	<input type="checkbox"/> Option 1:	<input type="checkbox"/> Option 2:	<input type="checkbox"/> 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.

Skilled Nursing to establish peripheral IV access as needed to manage 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:

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