VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
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 last dose: _____

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.

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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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:**	

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