


# VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

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

 option care health®	<b>Patient Name:</b>	<b>Date of Birth:</b>		
	<b>Address:</b>			
	<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>

## Clinical Information

<b>Primary Diagnosis Description:</b>	<b>ICD-10 Code:</b>
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<b>Is this the first dose?</b> <input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:	<b>Hepatitis B Status:</b> <input type="checkbox"/> Active TB <input type="checkbox"/> Unknown	<b>Titer Date:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative
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<b>TB Status:</b> <input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Last chest x-ray – date: <input type="checkbox"/> Past positive TB infection, course taken:	<input type="checkbox"/> Active TB <input type="checkbox"/> Unknown
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## Vedolizumab (Entyvio®) Prescription

**Vedolizumab (Entyvio®) 300 mg refill as directed x 1 year**

**Initial Dose:**  Infuse 300 mg IV over 30 to 60 minutes on Weeks 0, 2, and 6.  
 Other: \_\_\_\_\_

**Maintenance Dose:**  Infuse 300 mg IV over 30 to 60 minutes every 8 weeks.  
 Other: \_\_\_\_\_

Flush IV tubing with NS 30 to 50 mL after each infusion.

## Ancillary Orders

**Anaphylaxis Kit**  
If this is a 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?  
 Yes – please complete Anaphylaxis Physician Order (FR-PC-036) provided  No

**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.
- Loratadine 10 mg PO 30 min before infusion. Patient may decline.
- Methylprednisolone 40 mg IV push 20 minutes prior to infusion.
- Other: \_\_\_\_\_

**IV Flush Orders**

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 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 administer doses intravenously in the home or alternate care setting. 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.*

<b>Prescriber Signature:</b>	<b>Date:</b>
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## Prescriber Information

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

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