VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

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

option care health

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:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date: ☐ Last chest x-ray – date: ☐ Past positive TB infection, course taken:	☐ Active TB ☐ Unknown

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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st 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.

Prescriber Signature: **Date:**

Prescriber Information

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

