

VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

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



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: Active TB
 Last chest x-ray – date: Unknown
 Past positive TB infection, course taken:

Vedolizumab (Entyvio®) Prescription

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

Initial Dose: Infuse 300 mg IV over 60 minutes on Weeks 0, 2, and 6.

Other: _____

Maintenance Dose: Infuse 300 mg IV over 60 minutes every 8 weeks.

Other: _____

Using a 50 mL bag, flush IV tubing with NS 30 mL after each infusion.

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) SQ 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) IV or IM; repeat x 1 in 15 min PRN no improvement.
 - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

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:

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