

**ORDERING OFFICE, ALSO FAX:**

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

# Vedolizumab (Entyvio)

Provider Order Form



Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:
Ordering Provider:		Provider NPI:
Referring Practice Name:		Phone: Fax:
Practice Address:		City: State: Zip Code:
<b>NURSING</b>		
<input checked="" type="checkbox"/> Provide nursing care per IVX Standard Nursing Procedures, including reaction management <input checked="" type="checkbox"/> TB status and date (Please provide results) _____		
<b>LABORATORY ORDERS</b>		
<input type="checkbox"/> CBC <input type="checkbox"/> every other dose <input type="checkbox"/> every _____ <input type="checkbox"/> CMP <input type="checkbox"/> every other dose <input type="checkbox"/> every _____ <input type="checkbox"/> CRP <input type="checkbox"/> every other dose <input type="checkbox"/> every _____ <input type="checkbox"/> Other:		
<b>PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)</b>		
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO <input type="checkbox"/> cetirizine (Zyrtec) 10mg PO <input type="checkbox"/> loratadine (Claritin) 10mg PO <input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV <input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV <input type="checkbox"/> Other: Dose:                      Route:                      Frequency:		
<b>INFUSION THERAPY</b>		
<input checked="" type="checkbox"/> Vedolizumab (Entyvio) in 250ml 0.9% sodium chloride or lactated ringer's, intravenous infusion <ul style="list-style-type: none"> <li><input type="checkbox"/> 300mg</li> <li>Frequency: <input type="checkbox"/> induction: week 0, 2, 6, and then every 8 weeks  <input type="checkbox"/> maintenance: every 8 weeks / <input type="checkbox"/> other: _____</li> <li>Infuse over 30 minutes</li> </ul> <input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at the completion of infusion <input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion <input type="checkbox"/> Patient is NOT required to stay for observation time <input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)		
<b>GENERAL PLAN COMMUNICATION</b>		
Special instructions/notes:		

**Ordering Provider: Initial here \_\_\_\_\_ and proceed to the next page.**

**ADULT REACTION MANAGEMENT**

- Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- If reaction occurs:
  - Stop infusion
  - Maintain/establish vascular access
  - Notify referring provider
  - Consider giving the following PRN
    1. Acetaminophen (Tylenol) 650mg PO **OR** \_\_\_\_\_mg for pain or fever > 38 C/100.4 F
    2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
    3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
    4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
    5. Methylprednisolone (Solumedrol) 125mg **OR** \_\_\_\_\_mg slow IV push.
    6. Other \_\_\_\_\_
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines
- Severe allergic/anaphylactic reaction:**
  - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
    1. Call 911
    2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
    3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
    4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
    5. Have Automated External Defibrillator available
    6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
    7. Discontinue treatment

\*Exercise caution when considering the use of Entyvio in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Provider Name (Print)**

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**

**Designate the desired location and fax the order form to:**

**CALIFORNIA fax: (844) 889-0275** | \_\_\_San Mateo \_\_\_Fremont \_\_\_San Ramon \_\_\_TBD

**ILLINOIS fax: (312) 253-7244** | \_\_\_Glenview \_\_\_Schaumburg \_\_\_TBD

**KANSAS / MISSOURI fax: (844) 900-1292** | \_\_\_Overland Park, KS \_\_\_Lee's Summit, MO \_\_\_Briarcliff, MO \_\_\_TBD

**OHIO fax: (844) 627-2675** | \_\_\_Dublin \_\_\_Pickerington \_\_\_TBD

**PENNSYLVANIA fax: (844) 820-9641** | \_\_\_Malvern \_\_\_Bensalem \_\_\_Montgomeryville \_\_\_East Shore \_\_\_West Shore \_\_\_TBD

**TENNESSEE fax: (844) 627-2518** | \_\_\_Brentwood \_\_\_Hendersonville \_\_\_TBD

