Vedolizumab (Entyvio)

Provider Order Form rev. 10/30/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Crohn's Disease: Ulcerative Colitis:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Entyvio 300mg IV in 250ml NS over a period of 30mins, flush with 30ml NS.

FREQUENCY *(Choose one)*

☐ Induction: week 0, 2, 6, and then every 8 wks
☐ Maintenance: every 8 weeks
☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: _____
☐ CMP ☐ at each dose ☐ every: _____
☐ LFT ☐ at each dose ☐ every: _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- abnormal vital signs, signs/symptoms of illness or active infection
- New onset fatigue, anorexia, abdominal pain, dark urine, or jaundice
- planned/recent surgical procedures
- neurological changes
- Recent live vaccines

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, colonoscopy, history of fistula, history of hospitalization for bleeding

Required Labs: Negative TB within 12 months, CRP, ESR, fecal calprotectin, Negative hep B

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.