

# Entyvio (vedolizumab) | Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## 1. For new patients, please submit with form:

- Copy of insurance card
- Patient demographics
- History & physical
- Most recent labs, TB screening if needed according to local practice

## 2. Patient Information

Male  Female Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lbs/kg  NKDA Allergies: \_\_\_\_\_  
Is this the first dose?  Yes  No, date of last infusion: \_\_\_\_\_ Next due: \_\_\_\_\_ Line type:  PIV  PICC  Port  Other

## 3. Diagnosis and Clinical Information

ICD-10 (required): \_\_\_\_\_ Primary diagnosis:  Ulcerative colitis  Crohn's disease  Other: \_\_\_\_\_

## 4. Prescription Information

<b>Medication</b>	Entyvio 300 mg single-dose vial
<b>Dose / Frequency</b>	<input type="checkbox"/> Initial <u>and</u> maintenance dosing: 300 mg IV at 0, 2 and 6 weeks, then every 8 weeks <input type="checkbox"/> Maintenance dosing only (initial dosing already complete): 300 mg IV every 8 weeks <input type="checkbox"/> Other: _____
<b>Directions</b>	<input checked="" type="checkbox"/> Reconstitute and dilute Entyvio per manufacturer guidelines <input checked="" type="checkbox"/> Infuse IV over 30 minutes. After infusion is complete, flush IV line with 30mL of 0.9% sodium chloride <input type="checkbox"/> Other: _____
<b>Quantity / Refills</b>	Dispense 1 month supply / Refill x 12 months <input type="checkbox"/> Other: _____ Dispense all medical supplies necessary for infusion

## 5. Additional Orders

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services policy and procedure

**Premedications:** Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

- Diphenhydramine 25-50mg PO. Patient may decline.
- Acetaminophen 325-650mg (OR \_\_\_\_\_ mg) PO. Patient may decline.
- Methylprednisolone 40 mg (OR \_\_\_\_\_ mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)
- Other: \_\_\_\_\_

RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

RN to monitor patient for at least 30 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician

## 6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: \_\_\_\_\_

## 7. Prescriber Information

Prescriber Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
License No.: \_\_\_\_\_ DEA NO.: \_\_\_\_\_ NPI: \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature (Substitution Permitted)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Physician Signature (Dispense as Written)**

\_\_\_\_\_  
Date

*By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services*

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