ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):

Yakima Outpatient Infusion Care
808 N 39th Ave Yakima WA 98902
Phone: 509-575-1174
Fax: 509-577-5021

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

VEDOLIZUMAB (Entyvio)

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE:

- ❑ Crohn's Disease (ICD-10: _____) ❑ Ulcerative colitis (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

***REQUIRED*:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

REQUIRED BASELINE LABS & INFORMATION:

- ✓ CBC & CMP within 30 days prior to first infusion
- ✓ Negative Latent TB Test (Date: _____ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: _____)

ROUTINE LABS: ☑ CMP | ☑ CBC | ❑ Other: _____
ROUTINE LAB FREQUENCY: ☑ Each Infusion | ❑ Other: _____

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

✓ **PRE-MEDICATIONS (OPTIONAL)** – Give 30 minutes prior to infusion
- ❑ Acetaminophen 650 mg PO x1 ❑ Diphenhydramine 25 mg PO x1
- ❑ Other: _____

✓ **Vedolizumab (ENTYVIO) 300 mg in 250 mL 0.9% sodium chloride Intravenous Infusion**
- ❑ Induction Frequency: Infuse at week 0, 2, 6, then every 8 weeks thereafter
- ❑ Maintenance Frequency: Infuse every 8 weeks
- ❑ Other Frequency: Infuse every _____ weeks **Attach documentation/rationale to support non-FDA dosing interval*

MONITORING: Vitals at baseline and at completion of infusion.
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

***DISCHARGE*:** 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

VEDOLIZUMAB (Entyvio)
MultiCare
Yakima Memorial Hospital