ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Vedolizumab (Entyvio):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Crohn's Disease Dx Code 555.9 ❑ Ulcerative Colitis Dx Code 556.9

❑ Other: _____

Failed ANTI-TFN Therapy: _____

Current/Previous other therapy & dose:_____

Latent TB Testing (required prior to 1st dose): Date _____ Type _____ Results _____

If treated for inactive TB, date & length of Tx:_____

LABS

Baseline Labs: CBC and CMP within 30 days prior to first infusion
Scheduled Labs: CBC and CMP every 6 months while vedolizumab therapy continues
If ALT/AST and/or Billirubin are elevated beyond the ULN range HOLD INFUSION and contact physician

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Vital signs: Check vital signs prior to, and 30 minutes AFTER, infusion. Contact provider if:

- Systolic blood pressure greater than _____ mmHg or less than _____ mmHg
- Pulse greater than _____ Temperature greater than _____ degrees F
- If stable 30 minutes post infusion, discharge patient to home

Contact provider if patient develops any serious infection

❑ INITIATION: Vedolizumab 300 mg in 250 mL 0.9% NS given IV over 30 minutes. Give on day 1, repeat dose at 2 weeks and at 6 weeks, then every 8 weeks
❑ MAINTENANCE: Vedolizumab 300 mg in 250 mL 0.9% NS given IV over 30 minutes every 8 weeks after initiation sequence

Optional Pre-medications:

❑ Acetaminophen 650 mg PO 30 min. pre-infusion q 4 hrs PRN aches or temperature change greater than 2˚F
❑ Diphenhydramine 25 mg PO prior to infusion
❑ Other pre-med _____

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, 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.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time
_____	_____	_____	_____

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
Vedolizumab (Entyvio) Infusion

MultiCare

78-0393-3MR (Rev. 9/24)