# VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

**Fax completed form, insurance information, and clinical documentation to:**

| | | | | | |
|---|---|---|---|---|---|
| YOUR INTELLIGENT HEALTH COMPANY. UBACARE | **Patient Name:** | | | **Date of Birth:** | |
| | **Address:** | | | | |
| | **Phone:** | **Height:** | ☐ inches ☐ cm | **Weight:** | ☐ lbs ☐ kg |

## Clinical Information

| | |
|---|---|
| **Primary Diagnosis Description:** | **ICD-10 Code:** |

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|---|---|
| **Is this the first dose?** ☐ Yes – date of first dose: ☐ No – date of next dose due: | **Hepatitis B Status:** Titer Date: ☐ Positive ☐ Negative |

| | | |
|---|---|---|
| **TB Status:** | ☐ PPD (negative) – date: | ☐ Active TB |
| | ☐ Last chest x-ray – date: | ☐ Unknown |
| | ☐ Past positive TB infection, course taken: | |

## Vedolizumab (Entyvio®) Prescription

**Vedolizumab (Entyvio®) 300 mg refill as directed x 1 year**

**Initial Dose:** ☐ Infuse 300 mg IV over 30 to 60 minutes on Weeks 0, 2, and 6.

☐ Other: _____

**Maintenance Dose**: ☐ Infuse 300 mg IV over 30 to 60 minutes every 8 weeks.

☐ Other: _____

Flush IV tubing with NS 30 to 50 mL after each infusion.

## Ancillary Orders

**Anaphylaxis Kit**

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes – please complete Anaphylaxis Physician Order (FR-PC-036) provided ☐ No

**Medication Orders**

- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.
- ☐ Loratadine 10 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- ☐ Methylprednisolone 40 mg IV push 20 minutes prior to infusion.

☐ Other: _____

**IV Flush Orders**

- ☐ Peripheral: NS 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

**Lab Orders**

- ☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

**Prescriber Signature:** **Date:**

## Prescriber Information

| | | | |
|---|---|---|---|
| **Prescriber Name:** | | **Phone:** | **Fax:** |
| **Address:** | | **NPI:** | |
| **City, State:** | **Zip:** | **Office Contact:** | |



 