# Entyvio (Vedolizumab)

Infusion Order Form – Page 1 of 1

## Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

## Patient Information

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

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

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

## Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

## Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
  - Patient has moderate to severe active Crohn's disease
  - Patient has moderate to severe active ulcerative colitis
  - TB status & date (list results here & attach clinicals)
  - Hep B antigen surface antibody test results
  - Most recent LFT test results

## Orders

**NURSING**

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

**LABORATORY**

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

**PRE-MEDICATION**

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

**THERAPY**

☑ **Vedolizumab** (Entyvio) in 250mL 0.9% sodium chloride or lactatedringer's, intravenous infusion

- Dose: ☑ 300mg
- Frequency: ☐ induction: week 0, 2, 6, and then every 8 wks
- Maintenance: ☐ every 8 weeks / ☐ other: _____
- Infuse over 30 minutes
- ☑ Flush with 30mL 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

**Exercise caution when considering the use of Entyvio in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.*

Provider Name (Print): Provider Signature: Date:

 

Harbor Health