



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Ht: _____ Wt: _____

IV access: _____

Allergies: _____

Entyvio (Vedolizumab) Order Form

◆ Orders are initiated unless crossed out by provider.

Box must be checked to initiate order.

Please complete this form and fax to (360)933-1197. Call our office for pharmacist recommendations.

Diagnoses: Crohn's Disease ICD-10: _____
 Ulcerative colitis ICD-10: _____
 Other: _____ ICD-10: _____

Has patient received Entyvio before? No Yes (date of last infusion: _____)
 Are all immunizations up to date? Yes No (recommended before initiating therapy – please indicate reason for exception: _____)

Medication Orders:

- ◆ Entyvio (Vedolizumab)
 - 300 mg IV over 30 minutes at 0, 2, and 6 weeks, then every 8 weeks thereafter
 - Other dose/instructions: _____
- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- ◆ If no central IV access, RN to insert peripheral IV, and rotate site as needed.
- ◆ Monitor for infusion/hypersensitivity reactions during infusions.
- ◆ Monitor for signs of infection or liver impairment before each infusion; contact prescriber if infection is present (dose may be held).
- ◆ Other: _____

Labs: CBC w/diff Each infusion Other frequency _____
 CMP Each infusion Other frequency _____
 Hepatic function panel Each infusion Other frequency _____
 Other: _____ Each infusion Other frequency _____
 Other: _____ Each infusion Other frequency _____

 Prescriber Signature

 Date

 Please Print Name