VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

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

option care health®

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

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

Is this the first dose?

☐ Yes – date of first dose: _____

☐ No – date of next dose due: _____

Vedolizumab (Entyvio®) Prescription

Vedolizumab (Entyvio®) refill as directed x 1 year

IV Regimen:

☐ Initial Dose**;** Infuse 300 mg IV over at least 30 minutes on Weeks 0, 2, and 6.

☐ Maintenance Dose; Infuse 300mg IV over at least 30 minutes every 8 weeks.

☐ Other: _____

SubQ Regimen:

☐ Initial dose Weeks 0 and 2; Infuse 300 mg IV over at least 30 minutes.

☐ Initial dose Week 6; Infuse 300mg IV over at least 30 minutes.

☐ Maintenance dose; Inject Prefilled Pen of 108 mg SubQ every 2 weeks.

☐ Other: _____

For IV doses, quantity sufficient of Entyvio® 300mg vials will be dispensed to the patient to complete the prescribed treatment plan. In addition, after each infusion the IV tubing will be flushed with NS 30ml using a 50ml bag.
For SubQ doses, quantity sufficient of Entyvio® 108mg Prefilled Pens will be dispensed to fulfill prescribed treatment plan.

Ancillary Orders

Anaphylaxis Kit

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

☐ Yes ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

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 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 decline.

☐ Methylprednisolone Succinate 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:**	

