

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

# Entyvio® (vedolizumab) Standard Plan of Treatment

Rev 4.28.25

## PATIENT DEMOGRAPHICS:

Patient Name: \_\_\_\_\_

Patient's Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Height in inches: \_\_\_\_\_ Weight: \_\_\_\_\_ LB or \_\_\_\_\_ KG Gender: \_\_\_\_\_ Allergies: \_\_\_\_\_ See list NKDA

## DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

K50.0	- Crohn's Disease (small intestine)	K50.9	- Crohn's Disease, Unspecified
K50.1	- Crohn's Disease (large intestine)	K51.8	- Other Ulcerative (chronic) Colitis
K50.8	- Crohn's Disease (small & large intestine)	K51.5	- Left sided Ulcerative (chronic) Colitis
K51.0	- Universal Ulcerative (chronic) Pancolitis	K51.9	- Ulcerative Colitis
	- Other: _____		

## REQUESTED DOCUMENTATION:

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	
5		THERAPY:	
6			

**Continue current order until insurance approved**

## MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive vedolizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new onset or deterioration neurological changes, and/or surgery.

### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

## MEDICATION/DOSE:

Entyvio® (vedolizumab) 300mg per 250ml NS IV to infuse over at least 30 minutes. After the infusion is complete, flush with 30ml NS.

## SPECIAL/LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

## FREQUENCY:

Induction: Infuse at week 0, week 2, week 6, then every 8 weeks thereafter

Induction: \_\_\_\_\_

Maintenance: Dosed every 8 weeks

Maintenance: Dosed every \_\_\_\_\_ weeks

Refills x 12 months unless noted otherwise here: \_\_\_\_\_

## LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

## PRESCRIBER INFORMATION:

PROVIDER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ NPI: \_\_\_\_\_

## PRESCRIBER SIGNATURE: (No stamp signatures)

## DATE:

Dispense as written/Brand medically necessary	Substitution permitted