Spectrum Health

Physician's Orders VEDOLIZUMAB (ENTYVIO) - ADULT, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:

- ☐ Induction Interval: Every 14 days for 2 doses
- ☐ Maintenance Interval: Every 56 days (starting at week 6)

Duration:

- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____
Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology ☐ Infectious Disease ☐ OB/GYN ☐ Rheumatology ☐ Cardiology ☐ Internal Med/Family Practice ☐ Other ☐ Surgery ☐ Gastroenterology ☐ Nephrology ☐ Otolaryngology ☐ Urology ☐ Genetics ☐ Neurology ☐ Pulmonary ☐ Wound Care

Site of Service

☐ SH Gerber ☐ SH Lemmen Holton (GR) ☐ SH Pennock ☐ SH United Memorial ☐ SH Helen DeVos (GR) ☐ SH Ludington ☐ SH Reed City ☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs. Verify that all INDUCTION/LOADING DOSES have been scheduled and offset appropriately when scheduling MAINTENANCE DOSES.

Provider Ordering Guidelines

☑ ONC PROVIDER REMINDER 12

VEDOLIZUMAB (ENTYVIO):

Assess therapeutic benefit; if none noted after treatment course reconsider use. Monitor for signs of infection especially respiratory and nasal ones, neurologic changes, and elevated LFTs. Be alert for infusion-related reactions or hypersensitivity. All immunizations should be up to date prior to initiation of treatment.

Crohn disease or ulcerative colitis: IV: 300 mg at 0, 2, and 6 weeks and then every 8 weeks thereafter. Discontinue therapy in patients who show no evidence of therapeutic benefit by week 14.

CAUTION - ENSURE APPROPRIATE TIMING OF THERAPY. Usual Induction therapy is administered weeks 0, 2, and 6. The Spectrum Health Therapy Plan for INDUCTION contains weeks 0 and 2. The MAINTENANCE therapy plan starts WEEK 6 and continues every 8 weeks. **ENSURE APPROPRIATE TIMING BETWEEN INDUCTION AND MAINTENANCE PLANS!!

Safety Parameters and Special Instructions

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6

Verify all INDUCTION/LOADING DOSES given prior to start of MAINTENANCE DOSES

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NOTE: ***Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.***

Patient Name

DOB

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Nursing Orders

☑ ONC NURSING COMMUNICATION 105
VEDOLIZUMAB (ENTYVIO):

Monitor for signs of infection especially respiratory and nasal ones, neurologic changes, and elevated LFTs. Be alert for infusion-related reactions or hypersensitivity. All immunizations should be up to date prior to initiation of treatment.

MEDICATION INFORMATION SHEET: FDA-approved patient medication guide, which is available with the product information and as follows, must be dispensed with this medication.

☑ ONC NURSING COMMUNICATION 100
May Initiate IV Catheter Patency Adult Protocol

Vitals

☑ Vital Signs
Routine, PRN, Starting S, Take vital signs at initiation and completion of infusion and as frequently as indicated by patient's symptoms

Labs

☑ Bilirubin Total
Status: Future, Expected: S, Expires: S+365, URGENT, Lab Collect, Blood, Blood, Venous

☑ Alanine Aminotransferase (ALT), Blood Level
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

☑ Aspartate Aminotransferase (AST) Level

☐ ~~Other Labs~~ Bilirubin Total
~~Status: Future, Expected: S, Expires: S+365, URGENT, Lab Collect, Blood, Blood, Venous~~

☐ Every __ days ☐ Until date _____
☐ Once ☐ 1 year
☐ ___# of treatments

Medication

☑ vedolizumab (ENTYVIO) 300 mg in sodium chloride 0.9 % 255 mL IVPB
300 mg, Intravenous, for 30 Minutes, Once, Starting S, For 1 Doses
Do not administer IV push or bolus. Following infusion, flush with 30 mL of sodium chloride 0.9%. Observe patients during infusion (until complete) and monitor for hypersensitivity reactions; discontinue if a reaction occurs.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician

EPIC VERSION DATE: 03/19/20

