Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Vedolizumab (Entyvio) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information							
Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____	

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: _____	☐ K50.80, K50.90 ☐ K51.30, K51.90 ☐ Other: _____	☑ J3380	☑ CPT Code: _____

Labs (prior to scheduling first infusion)	Other Labs:
☑ TB test, Hepatic (Liver) Function Panel	☐ _____ ☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Vedolizumab	IVPB	300 mg over 30 minutes	Once	☐ Initial: Week 0, 2, and 6 (total 3 doses) ☐ Maintenance: Every 8 weeks for ____ dose(s) ☐ Give on week 0, 2, 6 then every 8 weeks for ____ doses ☐ Other: _____

Order Comments: Do not administer by IV push or bolus. Reconstitute vial with 4.8 mL of SWFI (60 mg/mL). Add the 5 mL (300mg) of reconstituted vedolizumab solution to 250 mL of NS. Following infusion, flush with 30 mL of sterile sodium chloride 0.9% or LR.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			