Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

477 W. Horton Rd
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 declot 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