BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

# VEDOLIZUMAB ORDERS IV (Entyvio)

| REFERRAL CHECKLIST |
| --- |
| Please ensure the following information is included with your referral: |
| ☐ Patient Demographics and Contact Information |
| ☐ Patient Insurance Information |
| ☐ Completed H&P and Progress Notes Including Medications and Allergies |
| ☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis |
| ☐ Colonoscopy and pathology reports |
| ☐ CBC w/diff/CMP/fecal calprotectin/TB and HepB Screening |
| ☐ Completed and Signed Referral |
| Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient.<br>Thank you! |

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| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: | Prescriber Name: |
| Address: | NPI: |
| City, State, Zip: | Address: |
| Cell: Email: | City, State, Zip: |
| Ht: Wt: kg Last 4 of SSN: DOB: | Phone: Fax: |
| Allergies: | Contact Person: |

| REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change | |
|---|---|
| First dose? ☐ Yes ☐ No - Date of last infusion: | Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other |

| DIAGNOSIS |
|---|
| ☐ Dx code/description: |

| REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx | |
|---|---|
| Prior Therapies: | |
| ☐ Vedolizumab level and antibody results (if changing dose/frequency): | |
| ☐ Hepatitis B Screening: ☐ Positive ☐ Negative-Date: | ☐ TB Screening: ☐ Positive ☐ Negative-Date: |

## PRESCRIBING INFORMATION

**LAB ORDERS**

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Other:

**PREMEDICATIONS (administer 30 minutes prior to infusion)**

| | |
|---|---|
| Acetaminophen: ☐ 650mgPO ☐ 1000mgPO | Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV |
| Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV | Other: ☐ |

**MEDICATION**

| Medication | Strength | Dose/Directions | Quantity |
|---|---|---|---|
| ☒ **Vedolizumab (Entyvio)** | 300mg/vial | **Induction**<br>☐ 300mg at week 0,2, and 6, then | ☐ 3 vials<br>Refills: none |
| | | **Maintenance**<br>☐ 300mg every 8 weeks<br>☐ 300mg every weeks | ☐ 1 vial<br>Refills: |
| | | Infuse in 250ml 0.9%NS IV over 30 minutes | |

***If not specified, order will be valid for 1 year from the date of signature.***

## NURSING INSTRUCTIONS/EMERGENCY MEDICATION

| | |
|---|---|
| RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines<br>Post-Infusion:Use 50ml0.9%NS to flush residual priming volume | PIV:Flush 3-10mL0.9%NS before/after<br>PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final |

Administer the following medications as needed for infusion-related reactions per company protocol:
**Adults>40kg:**Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
**Pediatrics/Adults<40kg:**Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
**Oxygen(AIC/AIS only):**1-6L/min via NC/face mask; titrate to maintain $SpO_2$ 95-100%.

**Prescriber Signature X:** _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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Print, complete, and fax completed form to (406) 752-0443