SOMC Cancer Center & Infusion
Ph: (740) 356-7490
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Vedolizumb (Entyvio) Order Form

PATIENT & PRESCRIBER INFORMATION

Patient Name: ________________________________ DOB: _____________ Phone: (H) __________________ (C) __________________

Patient Address: ____

Ht.: _______ Wt.: _______ ☐lbs. ☐kg. Allergies: ____

Prescriber Name/Title: ___________________________________ Address: ____

Phone: _______________________ Fax: _______________________ Prescriber NPI #: ____

***REQUIRED:* Most Recent H&P, clinical notes, & medication list are required unless the patient is established with SOMC. Supporting clinical notes should include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

DIAGNOSIS, CLINICAL INFORMATION, & PRESCRIPTION

☒ **Infusion rates will follow manufacturer recommendations.**

☒ **In the event of an adverse reaction, line maintenance/flushes, or O2 are required, the SOMC AIC established protocols will be utilized.**

☒ **0.9% NaCl 250 ml primary at KVO during infusion and for line flushing.**

☒ **Monitor for any adverse events post administration for at least 30 minutes or until clinically stable.**

Pre-Treatment Medications: (Check all that apply) **To be administered 30 minutes prior to each administration.**

☐ Acetaminophen (Tylenol) 650 mg by mouth x 1 dose

☐ 25 mg / ☐ 50 mg Diphenhydramine (Benadryl) ☐ PO or ☐ IV x 1 dose

☐ Methylprednisolone (Solumedrol) ______ mg IVP x 1 dose

☐ Other (**Please Specify**) –____

AND

Diagnosis (Check all that apply)

☐ Moderate to Severe Active Ulcerative Colitis

☐ Moderate to Severe Active Crohn's Disease

Dose:

☐ Vendolizumab (Entyvio) 300 mg IV Day 0, repeat dose at week 2 and week 6 and then every 8 weeks for up to ______ times

☐ Vendolizumab (Entyvio) 300 mg IV every 8 weeks x 1 year

☐ Vendolizumab (Entyvio) 300 mg IV every _______ weeks x 1 year

Additional order(s)____

Lab order(s)

☐ **CBC** ☐ **at each dose** **or** ☐ **every** _______

☐ **CBC w/ Diff** ☐ **at each dose** **or** ☐ **every** _______

☐ **CMP** ☐ **at each dose** **or** ☐ **every** _______

☐ **Other** – ____

PROVIDER:	DATE:	TIME:	SIGNATURE:

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