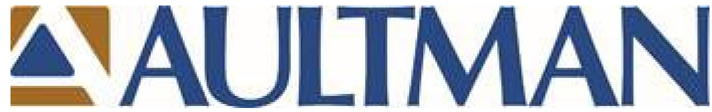

Aultman Infusion Services 2600 Sixth St. SW Canton, OH 44714
Ph 330-363-1410 Fax 330-363-2380

Infusion Order – Vedolizumab (Entyvio)

Name: ____ **DOB:** ______________________
Address: ____ **City:** ______________ **State:** ____ **Zip:** ______
Diagnosis: ____ **ICD-10:** ____________________
Allergies: ____

Treatment regimen

- **Vedolizumab** 300 mg in 250 mL 0.9% NaCl IVPB over 30 minutes

- **Please check one of the following frequencies:**
  - ☐ Administer on weeks 0, 2 and 6 then every 8 weeks thereafter
  - ☐ Administer every 4 weeks
  - ☐ Administer every 6 weeks
  - ☐ Administer every 8 weeks
  - ☐ Other ____

- **Flush IV line with 30-50mL 0.9% NaCl following completion of vedolizumab infusion**
- **Flush IV line using 10mL 0.9% NaCl flushes for IV start and as required**

- **Observe patient for at least 30 minutes following the completion of the first infusion for possible infusion-related reactions**

Duration of Order: 1 year (unless otherwise specified: ______________________________)

For Anaphylactic reactions, check which therapies to be included (patients >40kg):

- **Epinephrine** 1:1000, 0.3mg (0.3mL) IM x 1, may repeat every 5-15 minutes x 2 doses (or sooner if clinically indicated) if the patient does not respond.
- **Diphenhydramine** 50mg IV Push x 1 over 2 minutes
- **Sodium Chloride 0.9% 250mL** IV x 1 at 250mL/hour

Additional orders:

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Physician Signature: ______________________________________ **Print:** ____________________________________

Date: ____________________ **Phone:** ________________________________ **Fax:** ___________________________