

Patient Name
DOB
MRN
Physician
CSN

Physician's Orders VEDOLIZUMAB (ENTYVIO) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER Page 1 of 3

Defaults for orders not otherwise specified below:

- Interval: INDUCTION Every 14 days x 2 treatments
- □ Interval: MAINTENANCE Every 56 days (starting at week 6)

Duration:

- Until date: _____
- 1 year

□ _____# of Treatments

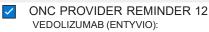
Anticipated Infusion Date ICD 10 Code with Description							
Height(cm)	Weight(kg) Allergies						
Site of Service							
CH Gerber	CH Lemmen Holton (GR)	CH Pennock	CH Greenville				
□ CH Helen DeVos (GR)	CH Ludington	□ CH Reed City	□ CH Zeeland				
CH Blodgett (GR)							
Provider Specialty							
Allergy/Immunology	Infectious Disease	□ OB/GYN	Rheumatology				
□ Cardiology	Internal Med/Family Practice	□ Other	□ Surgery				
□ Gastroenterology	Nephrology	Otolaryngology	Urology				
Genetics	Neurology	Pulmonary	Wound Care				

Appointment Requests

Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs. Verify that all INDUCTION/LOADING DOSES have been scheduled and offset appropriately when scheduling MAINTENANCE DOSES.

Provider Ordering Guidelines



Assess therapeutic benefit; if none noted after treatment course reconsider use. Monitor for signs of infection especially respiratory and nasal ones, neurologic changes, and elevated LFTs. Be alert for infusion-related reactions or hypersensitivity. All immunizations should be up to date prior to initiation of treatment.

Crohn disease or ulcerative colitis: IV: 300 mg at 0, 2, and 6 weeks and then every 8 weeks thereafter. Discontinue therapy in patients who show no evidence of therapeutic benefit by week 14.

CAUTION - ENSURE APPROPRIATE TIMING OF THERAPY. Usual Induction therapy is administered weeks 0, 2, and 6. The Spectrum Health Therapy Plan for INDUCTION contains weeks 0 and 2. The MAINTENANCE therapy plan starts WEEK 6 and continues every 8 weeks. **ENSURE APPROPRIATE TIMING BETWEEN INDUCTION AND MAINTENANCE PLANS!!

Safety Parameters and Special Instructions

ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6 Verify all INDUCTION/LOADING DOSES given prior to start of MAINTENANCE DOSES

CONTINUED ON PAGE 2 →

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

+

O Corewell Health[™]

(+)

VEDOLIZUMAB (ENTYVIO) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED) Page 2 of 3

Patient Name		
DOB		
MRN		
Physician		
CSN		

ursing (Page 2 of a						
	Hypersensitivity Re	action Adult Or	ncology Protocol		S	Ur	ntil discont'd	
	Routine, Until discor HYPERSENSITIVIT Discontinue the med	Y REACTIONS:	en released for 24 hou nediately.	rs				
			e or rapidly progressin icable) as needed for				P and have crash cart e specific emergency	
	Stay with patient un	il symptoms have re	esolved.					
	Initiate/Continue Ox	/gen to maintain Sp	O2 greater than 90%	and discontinue (Oxygen Therapy to	maintain SpO	2 above 90%	
	For severe or rapidly minutes until the pat		sensitivity reaction syr mptoms resolve.	mptoms, monitor v	vital signs and puls	e oximeter rea	adings every 2 to 5	
			oximate dose receive ion in patient medical					
~			ATION 105					
			ally respiratory and v. All immunizations				d LFTs. Be alert for infusi Itment.	on-
	MEDICATION INF as follows, must b			l patient medica	tion guide, which	is available	with the product information	on and
~	ONC NURSING							
als								
	Vital Signa							
~	Vital Signs Routine, PRN, Sta	arting S, Take vital	l signs at initiation a	and completion c	f infusion and as	frequently a	s indicated by patient's sy	mptoms
bs								
				In	terval	[Duration	
~	Bilirubin Total Status: Future, E	<pre>kpected: S, Expire</pre>	es: S+365, URGEN					
<u>~</u>		•	LT), Blood Leve es: S+365, URGEN ⁻		Blood, Blood, Ve	enous		
~	Aspartate Amir Status: Future, Ex		(AST) Level S: S+365, URGENT	, Clinic Collect, I	Blood, Blood, Ve	nous		
	Other Labs:				Everyc Once	days	1 year	
					0100		# of Treat	ments

(+)

(+)

CONTINUED ON PAGE 3 →

Corewell Health

VEDOLIZUMAB (ENTYVIO) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED) Page 3 of 3

Patient Name
DOB
MRN
Physician
CSN

Medication

+

vedolizumab (ENTYVIO) 300 mg in sodium chloride 0.9 % 250 mL IVPB 300 mg, Intravenous, Administer over 30 Minutes, Once, Starting S, For 1 Dose Do not administer IV push or bolus. Following infusion, flush with 30 mL of sodium chloride 0.9%. Observe patients during infusion (until complete) and monitor for hypersensitivity reactions; discontinue if a reaction occurs.

+

+

Telephone order/Verbal order documented and read-back completed. Practitioner's initials $_$

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		VALIDATED:		ORDERED:			
TIME	DATE	TIME	DATE	TIME	DATE	Pager #	
			R.N.		Physici	an	Physician
	Sign		Sign		Pr	nt	Sign

EPIC VERSION DATE: 03/19/20