

## 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

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> CH Gerber           | <input type="checkbox"/> CH Lemmen Holton (GR) | <input type="checkbox"/> CH Pennock   | <input type="checkbox"/> CH Greenville |
| <input type="checkbox"/> CH Helen DeVos (GR) | <input type="checkbox"/> CH Ludington          | <input type="checkbox"/> CH Reed City | <input type="checkbox"/> CH Zeeland    |
| <input type="checkbox"/> CH Blodgett (GR)    |  |                                       |  |

## Provider Specialty

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease           | <input type="checkbox"/> OB/GYN         | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology         | <input type="checkbox"/> Internal Med/Family Practice | <input type="checkbox"/> Other          | <input type="checkbox"/> Surgery      |
| <input type="checkbox"/> Gastroenterology   | <input type="checkbox"/> Nephrology                   | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology      |
| <input type="checkbox"/> Genetics           | <input type="checkbox"/> Neurology                    | <input type="checkbox"/> Pulmonary      | <input type="checkbox"/> 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

ONC PROVIDER REMINDER 12  
VEDOLIZUMAB (ENTYVIO):

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.**

# VEDOLIZUMAB (ENTYVIO) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED)

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Nursing Orders

Page 2 of 3

Patient Name

DOB

MRN

Physician

CSN

## ☒ Hypersensitivity Reaction Adult Oncology Protocol

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Until discont'd

Routine, Until discontinued Starting when released for 24 hours

**HYPERSENSITIVITY REACTIONS:**

Discontinue the medication infusion immediately.

Activate emergency response for severe or rapidly progressing symptoms. Where available consider calling RAP and have crash cart available. Call 911 or code team (if applicable) as needed for an absence of pulse and respirations. Refer to site specific emergency response policy.

Stay with patient until symptoms have resolved.

Initiate/Continue Oxygen to maintain SpO2 greater than 90% and discontinue Oxygen Therapy to maintain SpO2 above 90%

For severe or rapidly progressing hypersensitivity reaction symptoms, monitor vital signs and pulse oximeter readings every 2 to 5 minutes until the patient is stable and symptoms resolve.

Document medication infusing and approximate dose received at time of reaction in the patient medical record. Document allergy to medication attributed with causing reaction in patient medical record. Complete Adverse Drug Reaction form per Pharmacy Clinical Policy.

## ☒ ONC NURSING COMMUNICATION 105

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.

MEDICATION INFORMATION SHEET: FDA-approved patient medication guide, which is available with the product information and as follows, must be dispensed with this medication.

## ☒ ONC NURSING COMMUNICATION 100

May Initiate IV Catheter Patency Adult Protocol

### Vitals

## ☒ Vital Signs

Routine, PRN, Starting S, Take vital signs at initiation and completion of infusion and as frequently as indicated by patient's symptoms

### Labs

## ☒ Bilirubin Total

Status: Future, Expected: S, Expires: S+365, URGENT, Lab Collect, Blood, Blood, Venous

## ☒ Alanine Aminotransferase (ALT), Blood Level

Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

## ☒ Aspartate Aminotransferase (AST) Level

Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous

## ☐ Other Labs:

☐ Every \_\_\_ days

☐ Once

☐ 1 year

☐ \_\_\_\_\_ # of Treatments

# 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.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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:		Pager #
TIME	DATE	TIME	DATE	TIME	DATE	
Sign		R.N. Sign		Physician Print		Physician Sign

**EPIC VERSION DATE:** 03/19/20