Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

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

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. SE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
35 Michigan St. NE Floor 2
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion**
145 Michigan St. NE Ste 5200
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave. NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Pennock Hospital**
1009 W Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 S 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0195

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Ste 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 26 Mile Rd. Ste 3300
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 W 7 Mile Rd. Ste 3000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Ste 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St. Joseph Ave. Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

CONTINUED ON PAGE 2 ➔

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

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.

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

Infusions:

Anticipated Infusion Date: _____ **ICD-10 Code with Description:** _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected:

☒ Bilirubin Total
- ☒ Every visit
- ☐ _____

☒ Alanine Aminotransferase (ALT), Blood Level
- ☒ Every visit
- ☐ _____

☒ Aspartate Aminotransferase (AST) Level
- ☒ Every visit
- ☐ _____

☐ Additional lab order(s) _____
- ☐ Every visit
- ☐ _____

Treatment

☐ **INDUCTION –** Every 14 days x 2 treatments
☐ **MAINTENANCE –** Every 56 days (starting week 6)

Duration: ☐ 1 Year ☐ Until Date: _____ ☐ # of Treatments _____

☒ Vedolizumab (ENTYVIO) 300 mg IVPB
Administer over 30 minutes

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

Supplemental Orders

*****The following orders will be applied to the patient's plan unless otherwise indicated*****

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 Corewell 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 5**

Consider TB screening prior to treatment and as needed based on local practice and patient risk factors.

☒ **ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6**

Verify all INDUCTION/LOADING DOSES given prior to start of MAINTENANCE DOSES

Nursing Orders

☒ **ONC NURSING COMMUNICATION 105**

VEDOLIZUMAB (ENTYVIO):

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 9**

Check that labs indicated for THIS Treatment Cycle have been drawn within the last 96 hours or draw them in clinic prior to beginning treatment.

☒ **ONC NURSING COMMUNICATION 200**

May Initiate IV Catheter Patency Adult Protocol

☒ **Hypersensitivity Reaction Adult Oncology Protocol**

Until discontinued Starting when released Until Specified

Vitals

☒ **Vital Signs**

Routine, PRN Starting when released Until Specified

Take vital signs at initiation and completion of infusion and as frequently as indicated by patient's symptoms

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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 #
	Sign		**R.N. Sign**		**Physician Print**	**Physician Sign**

EPIC VERSION DATE: 03/19/20

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