Spectrum Health Helen DeVos children's hospital

Physician's Orders VEDOLIZUMAB (ENTYVIO) - PEDIATRIC, OUTPATIENT, INFUSION CENTER

Patient Name

DOB

MRN

Physician

FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Every 14 days x 2 treatments (Induction)
- ☐ Interval: Every 28 days (Maintenance)

Duration:
- ☐ Until date: __________
- ☐ 1 year
- ☐ ______# of Treatments

Anticipated Infusion Date_____________ ICD 10 Code with Description_____________________________________

Height_____________(cm) Weight____________(kg) Allergies____

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

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

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.

Safety Parameters and Special Instructions

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6

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

Provider Reminder

☑ ONC PROVIDER REMINDER

Premedication is not required, but can be considered for the prevention of subsequent infusion reactions. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions Therapy Plan".

☑ ONC PROVIDER REMINDER 16

After completion of initial 2 doses of Vedolizumab, order "Vedolizumab Maintenance Therapy Plan".

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

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VEDOLIZUMAB (ENTYVIO) - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name

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Pre-Medications

Acetaminophen Premed-select Susp,tab Or Chewable.

☐ acetaminophen (TYLENOL) 32 MG/ML suspension 10 mg/kg (Treatment Plan)
10 mg/kg, Oral, Once, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

☐ acetaminophen (TYLENOL) tablet 10 mg/kg (Treatment Plan)
10 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day.

☐ acetaminophen (TYLENOL) dispersable / chewable tablet 10 mg/kg (Treatment Plan)
10 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 1000mg
No more than 5 doses from all sources in 24 hour period, not to exceed 4000mg/day

Diphenhydramine Premed-select Cap,liquid Or Injection.

☐ diphenhydrAMINE (BENADRYL) capsule 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Oral, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ diphenhydrAMINE (BENADRYL) injection 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Intravenous, Once, Starting S, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ methylPREDNISolone sodium succinate (SOLU-Medrol) injection 0.5 mg/kg (Treatment Plan)
0.5 mg/kg, Intravenous, for 15 Minutes, Once, For 1 Doses
Recommended maximum single dose is 80mg
To reconstitute Act-O-Vial: Push top of vial to force diluent into lower compartment, then gently agitate. NON Act-O-Vials may be reconstituted with 2 mL of 0.9% sodium chloride for injection or bacteriostatic water for injection

☐ Premedication with dose: ____

Medications

☑ vedolizumab (ENTYVIO) 300 mg in sodium chloride 0.9 % IVPB
300 mg, Intravenous, for 30 Minutes, Once, Starting S, For 1 Doses
Do not administer IV push or bolus. Do not shake. 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.

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VEDOLIZUMAB (ENTYVIO) - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name
DOB
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Physician
FIN

Nursing Orders

☑ ONC NURSING COMMUNICATION 1

- Obtain height and weight at each visit.
- Place intermittent infusion device if necessary.
- Do not administer if the solution is discolored or if foreign particulate matter is present. Solution should be clear or opalescent, colorless to light brownish yellow.
- Monitor vital signs with Pulse oximetry, Obtain temperature, heart rate, respiratory rate, blood pressure and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes through 30 minutes after drug completion.
- Notify attending physician, NP or PA-C and stop drug infusion immediately if patient has itching, hives, swelling, temperature greater than 101 degrees Fahrenheit, rigors, dyspnea, cough or bronchospasm. Notify if greater than 20% decrease in systolic or diastolic blood pressure.
- Monitor for any new onset or worsening of neurological signs and symptoms.
- At the end of infusion, flush secondary line with at least 30 mL of 0.9% Sodium Chloride.
- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.
- Discharge patient to home after infusion if no signs/symptoms of reaction.

Labs

		Interval	Duration
☐	Complete Blood Count w/Differential STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Complete Blood Count W/ Manual Differential STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Comprehensive Metabolic Panel (CMP) STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Sedimentation rate STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	C Reactive Protein (CRP), Blood Level STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments

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VEDOLIZUMAB (ENTYVIO) - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

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		Interval	Duration
☐	Reticulocyte Count with Reticulocyte Hemoglobin STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Hepatic Function Panel (Liver Panel) STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Ferritin, Blood Level STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Iron and Iron Binding Capacity Level STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Vitamin D 25 Hydroxy STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Thiopurine Metabolites STAT, Starting S, For 1 Occurrences Current Therapeutic Name: Current Dose mg/day: Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Anser IFX STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	TB Screen (Quantiferon Gold) STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ *Every* ___days ☐ Once	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments
☐	Other Labs: ____	☐ *Every* ___days ☐	☐ Until date: ______ ☐ 1 year ☐ ______# of Treatments

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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: **TIME** **DATE**	**VALIDATED:** **TIME** **DATE**	**ORDERED:** **TIME** **DATE**	Pager #
Sign	**R.N. Sign**	**Physician Print**	**Physician**

EPIC VERSION DATE: 03/19/20

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