



Patient Name  
DOB  
MRN  
Physician  
FIN

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**

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

**Provider Specialty**

- Allergy/Immunology
- Cardiology
- Gastroenterology
- Genetics
- Infectious Disease
- Internal Med/Family Practice
- Nephrology
- Neurology
- OB/GYN
- Other
- Otolaryngology
- Pulmonary
- Rheumatology
- Surgery
- Urology
- 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.**

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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**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 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  Until date: \_\_\_\_\_  
 Once  1 year  
 \_\_\_\_\_ # of Treatments

**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.

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