Patient Name:
DOB:
Date of Last Infusion
Insurance:

<u>Clinic Location:</u>
Merrimack, NH☐
Concord, NH ☐

Vedolizumab (Entyvio®) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_________ Crohn's Disease (ICD-10)

_________ Ulcerative Colitis (ICD-10)

_________ Other: ____ (ICD-10) (description)

- Hold infusion and notify provider for:
  - Abnormal vital signs
  - Fever, signs or symptoms of illness or active infection,
  - Planned/recent surgical procedures
  - Neurological changes
  - Recent live vaccinations
- If infusion-related reaction occurs, stop infusion, notify provider and follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Administer vedolizumab 300 mg in 250 mL 0.9% sodium chloride over a period of 30 minutes. Flush with 30 ml 0.9% sodium chloride following infusion.

Frequency (chose one):

☐ On weeks 0, 2, 6, then every 8 weeks

☐ Every 8 weeks

☐ Every __________ weeks

Additional Orders:

Provider name (print): ____ Date:__________________

Provider signature: ____ Time: _________________

Revised 8/23/18. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.