aleracare
advanced home infusion

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Entyvio (vedolizumab)

Provider Order Form rev. 10/24/24

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ K51.80 Ulcerative colitis

◯ K51. 90 Ulcerative colitis, unspecified, without complications

◯ K50.90 Crohn's disease, unspecified, without complications

◯ K50.00 Crohn's disease of small intestine without complications

◯ K50.10 Crohn's disease of large intestine without complications

◯ Other: _____

Medication Order

Entyvio (vedolizumab) **Dose:** ◯ 300mg IV over 30 min

Frequency: ◯ Week 0, 2, 6 and then every 8 weeks thereafter Qty: 3 doses

◯ Every 8 weeks Qty: 1 dose

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (TB test) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order *(given 30 min before each infusion)*

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

diphenhydrAMINE (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

cetirizine (ZyrTEC) ◯ 10mg PO

methylPREDNISolone (SOLU-Medrol) ◯ 40mg IV ◯ 125mg IV

loratadine (Claritin) ◯ 10mg PO

hydrocortisone (Solu-CORTEF) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

◯ RN to administer 3-10 mL normal saline prior to medication and 30 mL normal saline after medication with heparin 100 units/mL 1-5 mL per SASH method

◯ Do NOT administer heparin to this patient

◯ Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

◯ Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

◯ Additional orders: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____

Provider Name _____ Provider Signature _____ Date _____

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order ◯