



**OUTPATIENT
VEDOLIZUMAB (ENTYVIO) INFUSION ORDERS**

ENTYVIO INFUSION ORDERS

Patient Name: _____ Date of Birth: _____

Diagnosis: _____

NOTE: Screen patients at each visit for active infection before any treatment is given, including TB. If active infection present, notify provider immediately. Screen patients for pregnancy status and notify provider for possible pregnancy. Notify provider of any new onset or worsening of neurological signs and symptoms. Notify provider of any signs and symptoms suggestive of hepatic injury (fatigue, jaundice, dark urine, anorexia, nausea, vomiting, right upper abdominal discomfort).

The following orders will be enacted unless a specific order is written to the contrary:

1. RN to review "Med Guide" with patient prior to each treatment.
2. Live vaccinations should not be given concurrently with Entyvio unless the benefits outweigh the risks.
3. **Please check to activate each order desired:**
 - Entyvio 300 mg IV over 30 minutes. Following infusion, flush line with 30 ml 0.9% sodium chloride.
 - Entyvio schedule of infusions:
 - Day 0 Week 2 Week 6 Every 8 weeks X 12 months
4. Premedication: If a patient has experienced a mild infusion-related or hypersensitivity reaction to Entyvio, consider administration of premedication prior to subsequent infusions ('Check' to activate):

<input type="checkbox"/> Acetaminophen (Tylenol) 500mg PO X 1	<input type="checkbox"/> Patient instructed to take at home
<input type="checkbox"/> Loratadine (Claritin) 10mg PO X 1 --OR--	<input type="checkbox"/> Patient instructed to take at home
<input type="checkbox"/> Diphenhydramine (Benadryl) 50mg PO X 1	
<input type="checkbox"/> Prednisone _____ mg PO PM night before infusion	<input type="checkbox"/> Patient instructed to take at home
<input type="checkbox"/> Prednisone _____ mg PO AM morning of infusion	<input type="checkbox"/> Patient instructed to take at home

5. Infusion Reaction protocol

For **minor** infusion reaction (e.g., fever, nausea, flushing)

- Continue infusion; monitor patient closely

For **moderate** infusion reaction (e.g., pruritus, rash, dizziness)

- STOP infusion
- Give diphenhydramine (Benadryl) 25mg IV x 1 dose
- May restart infusion after 15 minutes at a rate of 125 ml/hr (1/4 of previous rate) only if patient is asymptomatic and vital signs are stable.
- Notify provider

For **severe** reactions including anaphylaxis (e.g, dyspnea, bronchospasm, urticaria, rash, hypertension, tachycardia)

- **STOP administration of Entyvio immediately**
- Epinephrine (EpiPen) 0.3mg (0.3ml) IM x 1 STAT, administered into anterolateral aspect of the thigh
- **Methylprednisolone (Solu-Medrol) 40 mg IV x 1 dose**
- Diphenhydramine (Benadryl) 25 mg IV X 1 dose
- Notify provider
- Transport the patient to the Emergency Department

PHYSICIAN SIGNATURE

DATE/TIME

Short Stay Schedule (for office use only):

Day # 0: _____

Week # 2: _____

Week # 6: _____

Every 8 weeks thereafter:
