Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387 Fax: 541-242-4634

Vedolizumab (Entyvio) Orders

Name: _____ DOB: _____

Diagnosis/Indication: _____ ICD-10 Code: _____

1. Vital signs: Initial, then every 15 mins until infusion is completed
2. Peripheral IV site with saline lock
3. Infuse Entyvio (Vedolizumab) 300 mg IV in 250 mL 0.9% NaCl over 30 minutes. Following infusion, flush with 30 mL of sterile 0.9% NaCl. Give at 0, 2 weeks, 6 weeks and then every 8 weeks thereafter.
4. Pre-medications to be given 30 minutes prior to infusion (optional)

   ☐ OMG Infusion Center Pre-Medication Protocol

   OR

   ☐ Administer the following routine pre-medications prior to each infusion

   - ☐ Acetaminophen (Tylenol) 650 mg PO
   - ☐ Antihistamine (Select one)
     - ☐ Diphenhydramine (Benadryl) 25 mg PO
     - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
     - ☐ Loratadine (Claritin) 10 mg PO
   - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
   - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
   - ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV

   ☐ Other: _____
5. For infusion reaction (**Must select one to be considered a complete order**)

   ☐ Acute Infusion Reaction Protocol

   ☐ Other _____

Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order (non-OMG providers). A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order (non-OMG providers).

Provider Signature: _____ Date: _____
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: _____Time: _____