Vedolizumab (ENTYVIO)

TOTAL INFUSION
human-centered care

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Name: _____

DOB: _____ Phone: _____

Gender: ☐ Male ☐ Female

Allergies: _____

DIAGNOSIS (ICD-10 code required):

☐ _____ Ulcerative Colitis

☐ _____ Crohn's Disease

☐ _____ Other: _____

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Ensure baseline PPD or quantiFERON-TB assay for latent TB
- Ensure all immunizations are current before initiating therapy
- CBC, AST, and ALT every 8 weeks

TREATMENT CRITERIA:

Hold Vedolizumab (ENTYVIO) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Taking antibiotics for current infection
- *Initial dose only:* Unable to verify negative TB results

Notify Provider if:

- CBC, AST, and ALT have not been drawn within the last 12 weeks
- New or worsening neurological symptoms, such as memory loss, trouble thinking, dizziness, loss of balance, loss of vision, difficulty talking or walking
- Symptoms of liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice

Nursing Considerations:

- Ensure CBC, AST, and ALT have been drawn within the last 8 weeks, if not, proceed with infusion and instruct patient to have labs drawn today
- Monitor for adverse reaction including vital signs and pulse ox, every 15 minutes during infusion

Special Instruction(s):

Premedications

☑ **Acetaminophen (TYLENOL) 650mg PO**, Once, 30 minutes prior to Vedolizumab infusion.

☑ **Cetirizine (ZYRTEC) 10mg PO**, Once, at least 30 minutes prior to Vedolizumab infusion.

☑ **Hydrocortisone Sodium Succinate (SOLU-CORTEF) 50mg IVP (NOT ROUTINE; ONLY IF BREAKTHROUGH REACTION)** Once PRN, 30 minutes prior to Vedolizumab infusion in addition to Acetaminophen and Cetirizine if patient experiences symptoms with Acetaminophen and Cetirizine alone.

Medications

Patient Weight _____kg **(REQUIRED)**

Infuse **Vedolizumab (ENTYVIO)** Intravenously over 30 minutes; after the infusion is complete, flush with 30 mL of sterile 0.9% Sodium Chloride injection.

Dose:

☐ 300mg

☐ _____

Frequency:

☐ **Induction + Maintenance:** Every 2 weeks x 2 doses, then every 4 weeks x 1 dose, then every 8 weeks thereafter

☐ **Maintenance:** Every 8 weeks

☐ _____

☑ **IV LINE CARE** per Nursing Policy

☑ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

☑ **TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Provider Signature _____ Date _____ Email _____

Printed Name _____ Phone _____ Fax _____

Office Contact _____ Phone _____ Email _____