



Vedolizumab (Entyvio) Order Set:

Patient Name: _____ DOB: _____
Height: _____ Weight: _____ (kg) Allergies: _____

Assign as Outpatient

Diagnosis:

____ K50. ____ Crohn's Disease ____ K51. ____ Ulcerative Colitis
____ Other (ICD-10 Code): _____

Labs: To be completed per MD office as Outpatient prior to admittance to Infusion Center. Patient should be brought up to date on all immunizations

1. Negative TB skin test or other appropriate documentation of TB status must be faxed to 430-6976 prior to scheduling of appointment for patient.
2. Liver function tests

Nursing:

1. Confirm that patient is up to date on all immunizations.
2. Confirm TB and hepatitis B status (or has received hepatitis B vaccination). Assess patient for active infection prior to initiation of therapy: contact physician if present.
3. Assess other outpatient labs and report abnormalities to physician.
4. If emergency medications are needed once infusion initiated, STOP infusion, initiate emergency PRN medications and contact physician. May initiate oxygen therapy for emergency management via nasal cannula at 2 liters per minute. Keep O2 Sat above 95%

Medications:

1. Premedications:
 - ____ Acetaminophen 650 mg PO x 1 dose 30 minutes before start of infusion
 - ____ diphenhydrAMINE 25 mg PO x 1 dose 30 minutes before start of infusion
 - ____ methylPREDNISolone 40 mg IV x 1 dose 20 minutes before start of infusion
2. Sodium chloride 0.9% Infusion at 20ml/hr IV starting at treatment start time until discontinued
3. Line Care:
 - a) sodium chloride 0.9% flush 10ml IV flush as needed for line care
 - b) ____ Implanted port: heparin 100 units/ml flush 5ml IV as needed for line care
4. Vedolizumab – Flush with NS 50 ml after each infusion.
 - ____ **Initial Dosing Dose 1-2:**
Vedolizumab 300 mg in NS 250 ml IV over 30 minutes every 2 weeks x 2 doses.
 - ____ **Third dose:** Vedolizumab 300 mg in NS 250 ml IV over 30 minutes 6 weeks (42 days) after the 1st dose.
 - ____ **Subsequent Dosing:** Vedolizumab 300 mg in NS 250 ml IV over 30 minutes every 8 weeks at least 53 days apart (starting approximately 8 weeks after 3rd dose)
5. Emergency medications:
 - a) acetaminophen 650mg PO once as needed for temperature > 101
 - b) diphenhydrAMINE injection 25mg IVP once as needed for itching, facial flushing, hives, rash, SBP less than 90 mm Hg, wheezing, shortness of breath, or facial/lip tongue swelling. May repeat x 1 for a total of 50mg. Max dose for undiluted IV administration = 50mg given over 1 minute.
 - c) MethylPREDNISolone sodium succinate 125mg injection IVP once as needed for SBP less than 90 mm Hg, wheezing, shortness of breath, facial/lip/tongue swelling, itching, facial flushing, hives or rash unrelieved with diphenhydramine. May repeat x 1 for a total of 250mg.
 - d) Ondansetron 8mg IV once as needed for nausea or vomiting or infusion reaction



Patient: «Full_Name»; DOB: «Birth_Date»
Physician: «Attending_Physician_Last_Name», «Attending_Physician_First_Name» «Attending_Physician_Middle_Init»
Visit ID: «Visit_ID»



- e) _____ Promethazine 25mg tablet PO once as needed for nausea, vomiting or infusion reactions if ondansetron not ordered or ondansetron ineffective
- f) Famotidine 20mg injection IVP once as needed for anaphylaxis reaction in addition to diphenhydramine and methylprednisolone
- g) Sodium chloride 0.9% 500ml once as needed for SBP less than 90 mm Hg or suspected anaphylaxis in conjunction with all other medications used for hypotension or anaphylaxis

Discharge when infusion complete

New MD order required every 12 months

Physician Signature: _____ Date/Time: _____



Patient: «Full_Name»; DOB: «Birth_Date»

Physician: «Attending_Physician_Last_Name», «Attending_Physician_First_Name» «Attending_Physician_Middle_Init»

Visit ID: «Visit_ID»