Lake Charles Memorial Health System ℠

Vedolizumab (Entyvio) Order Set:
Patient Name: _____ DOB: _____
Height: _____ Weight: _____(kg) Allergies: _____

Assign as Outpatient

Labs: To be done per MD office as Outpatient prior to admittance to Infusion Center. Confirmation of hepatitis B status and a negative TB skin test (or other appropriate documentation of TB status) must be faxed to 430-6976 prior to scheduling of appointment for patient.

Diagnosis:
____K50.____Crohn's Disease   ____K51. ____ Ulcerative Colitis
____Other (ICD-10 Code): _____

Nursing: Confirm TB and hepatitis B status (or has received hepatitis B vaccination).
Prior to initiation of therapy, assess patient for:
- signs and symptoms of active infection
- any new onset of symptoms or current health concerns
  ***NOTIFY MD** if any of the above are present

Premedication:
____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
____Other: _____

Vedolizumab – Initial Dosing
____Vedolizumab 300 mg in NS 250 ml IV over 30 minutes at 0, 2 and 6 weeks. Flush with NS 50 ml after each infusion.
____Other: _____. Flush with NS 50 ml after each infusion.
Vedolizumab – Subsequent Dosing
____Vedolizumab 300 mg in NS 250 ml IV over 30 minutes every 8 weeks. Flush with NS 50 ml after each infusion.
____Other: _____. Flush with NS 50 ml after each infusion.

Severe Reactions: Stop infusion, initiate anaphylaxis protocol and notify MD.

IV Line Care:
- Normal Saline 10 ml IV flush after each use
- For implanted ports: Heparin 100 units/ml 5 ml IV flush after each use or prior to deaccessing

Discharge when infusion complete

New MD order required every 6 months unless defined in original order

Physician Signature: _____ Date/Time:_____