Holland Hospital

AMBULATORY TREATMENT UNIT

Vedolizumab (Entyvio) Infusion Order Set

☐ = Optional Order • = Routine Order (Cross out and initial bulleted orders that do not apply.)

Phone (616) 394-3547
Fax (616) 394-2139

ORDERS

Date: _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

TB Test Result: _____ **Date:** _____ **Initial TB Test required prior to first dose. Any subsequent testing optional, and to be ordered and evaluated by provider.*

MEDICATION

☐ Initial dose of vedolizumab (Entyvio) 300 mg IVPB, infuse over 30 minutes at 0, 2, and 6 weeks.
☐ Maintenance therapy of vedolizumab (Entyvio) 300 mg IVPB, infuse over 30 minutes every 8 weeks.

- Vital signs to be completed prior to infusion, 15 min after start of infusion and at the completion of infusion.
- If patient is in the induction period of their infusions, patient should be monitored for 30 minutes post infusion including vital signs 30 minutes after completion of infusion.
- If the patient has no improvement of symptoms 14 weeks after initial vedolizumab (Entyvio) dose, notify ordering provider.

Treatment for Adverse Drug Reactions (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes

Give:
- Diphenhydramine (Benadryl) - 25 mg IV Push,
- Acetaminophen (Tylenol) - 650 mg, Oral. As needed for reactions. For pain/fever. If not already given as a "premedication". *(Maximum Acetaminophen doses of 4000 mg in 24 hours from all combined sources.)*
- Methylprednisolone (Solu-Medrol) - 125 mg IV Push, if reaction continues

- Place O2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____

Order is in effect for six (6) months following order date.