



Oregon Health & Science University
Hospital and Clinics Provider's Orders

P07071



ADULT AMBULATORY INFUSION ORDER
Vedolizumab (ENTYVIO)

Page 1 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____ kg Height: _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. A PPD test must have been placed and read as negative within the past year (or QuantiFERON Gold blood test).
3. Hepatitis B (Hep B surface antigen and core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected.
4. Patients should not have an active ongoing infection, signs or symptoms of malignancy, or moderate to severe heart failure at the onset of therapy. Baseline liver function tests should be normal.
5. Patient should have regular monitoring for TB, hepatitis B, infection, malignancy, and liver abnormalities throughout therapy.

OTHER:

- Tuberculin (TUBERSOL, APLISOL) injection, 5 units, intradermal, ONCE, prior to initiation of therapy

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- Hepatitis B Surface AG, serum, Routine, ONCE
- Hepatitis B Core AB Qual, serum, Routine, ONCE

OR

- Hepatitis B surface antigen and core antibody test results scanned with orders

- Tuberculin Test Result. Date: _____ Positive / Negative

LABS:

- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One

MEDICATIONS:

- vedolizumab (ENTYVIO) 300 mg in NaCl 0.9%, IV, ONCE over 30 minutes

Interval (must check at least one)

- Initial dosing:** on week 0, 2 and 6
- Maintenance dosing:** every 8 weeks thereafter
- Other:** _____



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NURSING ORDERS:

1. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, then every 15 minutes until infusion is completed.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion-related events develop the infusion should be interrupted temporarily and the patient should be thoroughly assessed. If infusion-related events may consist of Temp greater than 38.5, rigors, SBP greater than 30 mmHg decrease from baseline, mucosal or respiratory (congestion/edema) distress, do the following:
 - a. Stop the infusion
 - b. Notify MD immediately
 - c. Treat symptoms using emergency medications as ordered
 - d. Monitor patient status and vital signs until stable
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

AS NEEDED MEDICATIONS:

- acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever, headache, chills, or malaise
- diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching



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By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

Beaverton

OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

NW Portland

Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

Gresham

Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

Tualatin

Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders