Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Entyvio Infusion Order (Revised 7/14/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form to desired location.

Required Lab Results: N/A

Infusion Therapy:

☒ Entyvio (vedolizumab) **300** mg IV over 30 minutes

☐ **Frequency:** week 0, 2, 6 and then every _____ weeks (loading and maintenance) **ICD 10 code: -** ________

☐ **Frequency:** every _____ weeks (maintenance only)

Pre-Meds:

Administer 30 minutes prior to Entyvio: ☐ No Pre-meds Needed

☐ Acetaminophen _____mg PO x 1

☐ Benadryl ____ mg PO or ____ mg IV x 1 (*if applicable, only choose one*)

☐ Loratadine 10 mg PO x 1

☐ SoluMedrol ____ mg IV x 1

PRN Medications:

☐ Zofran 4mg IV every 3 hours PRN nausea/vomiting

Additional Orders:

____

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.
- Do not administer Entyvio and notify ordering provider if patient has a temperature greater than 100°F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.
- Monitor for signs of reaction for 30 mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed

Provider Name: ____________________________________

Provider Signature: _________________________________

Date: ______ (Order valid for 1 year)

Patient Name:

DOB:

MRN: