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

Pediatric Entyvio Infusion Order (Revised 09/21/21)

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

Required Lab Results: Prior to first infusion Hep B and PPD/Quantiferon Gold (required prior to scheduling).

Infusion Therapy:

☐ Entyvio 300 mg IV over 30 minutes **ICD 10 code: _____**

☐ **Frequency:** weeks 0, 2, 6, then every _____ weeks (loading and maintenance) **OR**

☐ **Frequency:** weeks 0, 2, 6, then every _____ weeks (maintenance)

Pre-Meds: <u>Administer 30 minutes prior to Entyvio</u>

☐ Acetaminophen_____mg PO x 1

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

☐ SoluMedrol _____ mg IV x 1

☐ Zofran _____ mg x 1

☐ EMLA cream PRN prior to IV start

Anaphylaxis Medications:

☐ Epinephrine (1:1000) _____ mg SQ/IM; may be repeated after 5mins

☐ SoluMedrol _____ mg IV

☐ Benadryl _____ mg IV

Additional Orders:

_____

_____

Special Instructions:

- Labs: **CBC with diff, CMP, CRP, ESR, LFTs** Frequency: **with every infusion**
- 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.

Physician Name: _____
Physician Signature: _____
Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: