|  |  |
| --- | --- |
| **Patient:** | **DOB:**  |
| \*\*check appropriate box\*\***\*\*All orders with ☒ will be placed unless otherwise noted\*\*** |
| **ICD 10/Primary Diagnosis:**  | **ICD 10/Secondary Diagnosis:** |
| **Height:** | **Weight:** | **Allergies:** |
| **Infusion Therapy**  | **Frequency** |
| [x]  **Entyvio (vedolizumab)** 300 mg IV over 30 minutes | **Frequency:**[ ]  **Loading & Maintenance** Week 0, 2, 6 and every \_\_\_\_\_\_\_\_\_\_\_\_ weeks[ ]  **Maintenance only:**  Every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weeks |
| **Pre-Medication** [ ]  **NO PRE-MEDICATION REQUIRED**  |
| **Pre-medications administered 30 min prior to infusion** |
| **Medication** | **Dose**  | **Route** | **Medication** | **Dose** | **Route** |
| [ ]  Benadryl |  | IVP | [ ]  Solu-Medrol |  | IVP |
| [ ]  Benadryl |  | PO | [ ]  Tylenol |  | PO |
| [ ]  Loratadine | 10 mg | PO |  |  |  |
|  **PRN MEDS:**[ ]  Zofran 4 mg IV every 3 hours PRN nausea/vomiting | **PRN EMERGENCY MEDS:**[x]  Per Facility protocol[ ]  Provider requested Emergency Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Labs** |
| **Labs to be drawn over treatment course by facility:**  [ ]  **NO LABS REQUIRED** |
| **LAB** | **FREQUENCY** | **LAB** | **FREQUENCY** |
|  |  |  |  |
|  |  |  |  |
| **Nursing Communication/Orders** |
| * 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.
* 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.
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**Entyvio (vedolizumab)**