Place Sticker Here

Vedolizumab (Entyvio) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

☐ K50.0___ Crohn's Disease (small intestine)

☐ K50.1___ Crohn's Disease (large intestine)

☐ K50.8___ Crohn's Disease (small & large intestine)

☐ K50.9___ Crohn's Disease, unspecified

☐ K51.8___ Other Ulcerative (Chronic) Colitis

☐ K51.5___ Left Sided Ulcerative (Chronic) Colitis

☐ K51.0___ Universal Ulcerative (Chronic) Pancolitis

☐ K51.9___ Ulcerative Colitis, unspecified

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

☐ None

☐ Acetaminophen 650 mg PO

☐ Diphenhydramine: Dose: ☐ 25 mg ☐ 50 mg Route: ☐ PO or ☐ IVP

☐ Methylprednisolone: Dose: ☐ 40 mg or ☐ 125 Route: IVP

☐ Famotidine: Dose: 20 mg Route: ☐ PO or ☐ IVPB

☐ Other (include drug, dose, and route): _____

Drug Orders:

- Vedolizumab (Entyvio) (J3380) 300 mg per 250 mL Sodium Chloride 0.9% IV to infuse over 30 minutes
- Frequency: ☐ Induction: Weeks 0, 2, and 6 then every 8 weeks thereafter
  ☐ Maintenance: every 8 weeks
  ☐ Other: _____
- Order Duration: Six months unless otherwise specified (Other: _____)

Lab Orders:

☐ _____

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received vedolizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)