Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Vedolizumab (Entyvio®)

Provider Order Form rev.

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:
Patient Address: Patient Email:
Allergies: ☐ NKDA Weight (kg): Height (cm):
Sex: ☐ M / ☐ F Date of Last Infusion: Next due date:
Insurance carrier: PA #: PA date:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

☐ Crohn's Disease: ☐ Ulcerative Colitis:
Other: Description:

THERAPY ADMINISTRATION & DOSING

☐Entyvio 300mg IV in 250ml NS over a period of 30mins, flush with 30ml NS.

FREQUENCY *(Choose one)*

☐ Induction: week 0, 2, 6, and then every 8 wks
☐ Maintenance: every 8 weeks
☐ Every ______weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: ___________
☐ CMP ☐ at each dose ☐ every: ___________
☐ LFT ☐ at each dose ☐ every: ___________
☐ Other: ______________________________

PRE-MEDICATION ORDERS

☐ Acetaminophen ☐ 500mg / ☐ 650mg PO
☐ Cetirizine 10mg PO
☐ Famotidine 20mg ☐ PO / ☐ IVP
☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Methylprednisolone ☐ 40mg / ☐ 125mg IVP
☐ Other: ______________________________

NURSING

☐Hold infusion and notify provider for:

- abnormal vital signs, signs/symptoms of illness or active infection
- New onset fatigue, anorexia, abdominal pain, dark urine, or jaundice
- planned/recent surgical procedures
- neurological changes
- Recent live vaccines

☐Provide nursing care and post- procedure observation per policy
☐In the event of an infusion reaction, per RRMC Infusion Reaction Management policy, the patient may receive:

- Acetaminophen 1000 mg orally
- Epinephrine 0.5 mg IM
- Diphenhydramine 25-50 mg IV push
- Normal saline IV at 150 mL/hr
- Methylprednisolone 125 mg IV push

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:
Ordering Provider: Provider NPI:
Referring Practice Name: Phone: Fax:
Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, colonoscopy, history of fistula, history of hospitalization for bleeding. **Required Labs:** Negative TB within 12 months, CRP, ESR, fecal calprotectin, Negative hep B

Provider Name *(print)* **Provider Signature** **Time** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

Form #5503 created 8/2025

White- Patient
Yellow- Medical Records

Patient Label