St. Clair Health

Intravenous Vedolizumab (Entyvio) Physician Order Set

POS-019

Name: _____ Date of Birth: _____

Allergies: _____

Diagnosis: _____ ICD-10 Code: _____

Ordering Physician Name (Print): _____

Please administer:

☐ **Vedolizumab (Entyvio) 300 mg at 0, 2, and 6 weeks and then every 8 weeks**

- ☐ **IV over 30 minutes**
- ☐ **IV over 2 hours**

OR

☐ **Vedolizumab (Entyvio) 300 mg every 8 weeks**

- ☐ **IV over 30 minutes**
- ☐ **IV over 2 hours**

If Given IV over 2 hours:

Infusion Rate Chart	
Infusion Rate	**Time (min)**
10 mL/hr	For 15 minutes
20 mL/hr	For 15 minutes
40 mL/hr	For 15 minutes
80 mL/hr	For 15 minutes
150 mL/hr	For 15 minutes
250 mL/hr	Until end of therapy

Assess for signs/symptoms of hypersensitivity &/or anaphylaxis

- If signs/symptoms of reaction, administer diphenhydramine 25 mg IV push (may repeat x 1 in 15 minutes) AND methylprednisolone 40 mg IV push
- Ondansetron 4 mg IVP x 1 for nausea

Also required from physician office:

- History and Physical *or* Assessment and Plan *or* Physician Office Progress Note(s)
- Insurance authorization

Authorization # and Dates *(from and to):* _____

Physician Office Phone: _____ **Fax:** _____

Physician Signature: _____ **Date:** _____ **Time:** _____

Fax order and medical record documentation to 412.942.3559

For Physician Sponsor:
I attest that I have reviewed the above order set and approve of all content, including any changes noted herein.

Name: _____ **Title:** _____

Signature: _____ **Date:** _____ **Time:** _____