PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

OUTPATIENT VEDOLIZUMAB (ENTYVIO) ORDERS

Diagnosis: ☐ Moderate to Severe Crohn's Disease
☐ Moderate to Severe Ulcerative Colitis **ICD10:** _____

Verification of T SPOT/PPD or Quantiferon: TB testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB. Please indicate date and result of test done:

T SPOT: Date: _____/_____/_____ Result: _____
Quantiferon TB Gold Test: Date: _____/_____/_____ Result: _____
PPD: Date: _____/_____/_____ Result: _____

IV Access:

☐ Saline Lock:
☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
☑ Discontinue Saline Lock after therapy completed
☐ PICC Line:
☑ Routine PICC Line Care, labs and restoration
☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
☐ Porta cath / Central Access Device (Hickman, Triple lumen):
☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Premedication:

☐ Acetaminophen (Tylenol) *650 mg, PO, ONCE*
☐ Cetirizine (Zyrtec) *10 mg, PO, ONCE*

Patient with risk of or confirmed previous adverse reactions:

☐ Famotidine (Pepcid) *20 mg, PO, ONCE*
☐ Hydrocortisone Sodium Succinate (Solu-Cortef) *100 mg, IVP, ONCE*

Medication:

☐ Wait for lab results before infusing Vedolizumab
☑ Vedolizumab (Entyvio) *300 mg/250 mL 0.9% Sodium Chloride, IVPB, Infuse over 30 minutes*

Treatment Schedule:

☐ *One time dose*
Initial therapy: ☐ *Weeks 0, 2 and 6 then* ☐ *Every 8 weeks or* ☐ *Every _____ weeks*
Maintenance: ☐ *Every 8 weeks or* ☐ *Every _____ weeks*
Duration: ☐ *6 months* ☐ *1 year*

Other: _____
_____
_____
_____

100000067

Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS