Place Patient Label Here

POS-019

St. Clair Hospital
Pittsburgh, PA 15243

Intravenous Vedolizumab (Entyvio)
Physician Order Set

Patient Name: _____ Date of Birth: _____

Allergies: _____

Diagnosis: _____ ICD-10 Code: _____

Ordering Physician Name (please 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 30 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 Signature: _____ **Date:** _____ **Time:** _____

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

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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