VEDOLIZUMAB (Entyvio) Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Diagnosis [ ] Crohn's disease [ ] Ulcerative colitis, [ ] Other:

Weight: _____kg Height: _____inches [ ] New treatment
[ ] Transfer – Receiving Vedolizumab since_____

Negative TB test date _____

- Screen for Hepatitis B infection: Hep B surface antigen, Hep B Antibody, Hep B Core Antibody total. .
- TB screen with PPD or IGRA before start of therapy if none in past 12 months. Repeat every 12 months. Notify provider of positive results.
- Provide patient with medication guide before administration of each dose. Allow the patient time to read and ask questions. Document process in chart.

PRE-MEDICATE (30 minutes before infusion) **or confirm patient has taken prior to arrival**

[ ] acetaminophen 1000 mg PO
[ ] loratadine 10 mg PO
[ ] diphenhydramine 25 mg PO
[ ] Methylprednisolone 40 mg IV
[ ] Hydrocortisone 50 mg IV
[ ] Other:

Vedolizumab 300 mg IV infused over 30 minutes. Follow with 30ml saline flush.

Initial therapy: Repeat infusion at 2 and 6 and 14 weeks.

Continued treatment: Continue therapy every 8 weeks x_____ months. (new order every 12 mos.)

Obtain provider documentation of therapeutic benefit.

Vital Signs: pre and post infusion. Patient may be discharged if post-infusion vital signs are stable.
Educate patient on signs and symptoms of severe infection.

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
Annually:
[ ] H&P completed with last year **[ ]** Copy of most recent TB test result (if none, IGRA will be done in clinic)

If new therapy:
[ ] Hep B screen or document of vaccination [ ] Documentation supporting diagnosis and prior therapies
[ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .

Contacted provider:_____

NOTE: Documentation must clearly demonstrate either:
- Inadequate response, loss of response or intolerance to TNF blockers (e.g. adalimumab, certolizumab) **–or-** immunomodulators (e.g. mercaptopurine, azathioprine)
- Inadequate response, intolerance, or demonstrated dependence on, corticosteroids.

Patient must not be receiving disease-modifying- antirheumatic drug, Janus kinase inhibitor, or natalizumab.

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Revised: 7/8/25

Provider signature _____Date_____time_____

If not RFGH credentialed: Printed name_____ Phone # _____

RFGH Co-signature _____

Date_____ time:_____

Patient _____

Dob_____ phone #_____