

VEDOLIZUMAB (Entyvio) Infusion

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 ☐ Methylprednisolone 40 mg IV
☐ loratadine 10 mg PO ☐ Hydrocortisone 50 mg IV
☐ diphenhydramine 25 mg PO ☐ 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 – please attach:

- ☐ H&P completed with last year ☐ Copy of most recent TB test result (if none, IGRA will be done in clinic)

If new therapy – please attach:

- ☐ Hep B screen or document of vaccination
☐ Documentation supporting diagnosis and prior therapies
☐ Problem list
☐ Current medication and allergies

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:9/2025

Provider signature _____ Date _____ time _____

Printed name _____ Phone # _____

Patient _____

dob _____ phone # _____