

vedolizumab (ENTYVIO) – Induction Only

Infusion Therapy Plan Orders

Page 1 of 3

Name: _____
Kaiser Permanente Member I.D. #: _____
Date of Birth: _____

Instructions to Provider

Review orders and note any changes. All orders with will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers using the link at the end of this protocol).
 Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all the following:

Order Date: _____	Diagnosis ICD-10 code (REQUIRED): _____
Weight: _____ kg	ICD-10 description: _____

General Plan Communication

- Induction: Infuse vedolizumab 300 mg at 0 and 2 weeks
- Maintenance: Subcutaneous vedolizumab 108 mg injection every 2 weeks starting at week 6. A pharmacy prescription is needed for maintenance dosing
- Discontinue therapy if no evidence of therapeutic benefit by week 14
- **Special instructions/notes:**

Provider Information

- Ensure baseline PPD or quantiFERON-TB assay are negative for latent TB.
- Treatment with vedolizumab not recommended in patients with active, severe infections. Consider withholding vedolizumab in patients who develop a severe infection while on treatment.
- Ensure an immunization plan is in place before initiating therapy.
- Live vaccines should not be given concurrently or within 3 months of discontinuation of therapy.
- Risk of developing Progressive Multifocal Leukoencephalopathy (PML): Monitor for new or worsening neurological signs or symptoms.
- Monitor for signs and symptoms of liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice.

Infusion Therapy

vedolizumab (ENTYVIO) 300 mg in 0.9% sodium chloride 250 mL IV infusion

Dose: 300 mg

Route: Intravenous

Frequency: Every 2 weeks for 2 doses

Infusion Rate: Infuse over 30 minutes, starting 60 minutes after treatment start time

If infusion-related reaction:

- 1) STOP infusion immediately
- 2) Begin primary infusion to wide open rate
- 3) Notify MD
- 4) Monitor vital signs
- 5) Administer PRN medications
- 6) 30 minutes after symptoms have resolved, restart infusion at 50% of rate when reaction occurred

Note any changes to above regimen:

Pre-Medications

acetaminophen (TYLENOL) tablet

Dose: 650 mg **Route:** Oral **Frequency:** Once PRN, 30 minutes prior to vedolizumab infusion if patient has history of prior reaction. May also be given once as needed during infusion for achiness, headache, or fever

Provider Signature: _____ Date: _____

Printed Name: _____ Phone: _____ Fax: _____

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Page 2 of 3

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<input checked="" type="checkbox"/>	cetirizine (ZYRTEC) tablet <i>Dose:</i> 10 mg <i>Route:</i> Oral <i>Frequency:</i> Once PRN, 30 minutes prior to vedolizumab infusion (if not taken at home) if patient has history of prior reaction
<input checked="" type="checkbox"/>	hydrocortisone sodium succinate (SOLU-CORTEF) injectable <i>Dose:</i> 50 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once PRN, 30 minutes prior to vedolizumab infusion (if not taken at home) in addition to acetaminophen and cetirizine if patient still experiences symptoms with acetaminophen and cetirizine alone
<input checked="" type="checkbox"/>	Other: _____ <i>Dose:</i> _____ <i>Route:</i> _____ <i>Frequency:</i> Once PRN, 30 minutes prior to vedolizumab infusion
IV Line Care	
<input checked="" type="checkbox"/>	0.9% Saline (NS) infusion 250 mL <i>Rate:</i> 30 mL/hr <i>Route:</i> Intravenous <i>Frequency:</i> Run continuously to keep vein open. Start peripheral IV if no central line
PRN & Hypersensitivity Reaction Medications	
<input checked="" type="checkbox"/>	acetaminophen (TYLENOL) tablet <i>Dose:</i> 650 mg <i>Route:</i> Oral <i>Frequency:</i> Take 650 mg PO every 4 hours PRN for fever (greater than 100.4 F), myalgias, arthralgias or headache.
<input checked="" type="checkbox"/>	alteplase (CATHFLO ACTIVASE) injection <i>Dose:</i> 2 mg <i>Route:</i> Intracatheter <i>Frequency:</i> Instill 2 mg to affected port(s) of central venous catheter if sluggish or occluded. Allow to dwell for 30 minutes, if unable to aspirate blood allow to dwell for an additional 90 minutes. May repeat one time if unsuccessful.
<input checked="" type="checkbox"/>	diphenhydrAMINE (BENADRYL) injectable <i>Dose:</i> 50 mg <i>Route:</i> Intravenous <i>Frequency:</i> Once PRN for urticaria, pruritus, shortness of breath. May repeat one time in 15 minutes if symptoms not resolved. Notify MD upon giving medication
<input checked="" type="checkbox"/>	famotidine (PEPCID) (PF) injection <i>Dose:</i> 20 mg <i>Route:</i> Intravenous <i>Frequency:</i> Give IV push over 2 minutes for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. Give immediately after diphenhydrAMINE. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	methylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF) <i>Dose:</i> 125 mg <i>Route:</i> Intravenous <i>Frequency:</i> Give 125 mg IV push one time PRN for shortness of breath, bronchospasm, or other symptoms of a suspected hypersensitivity reaction not otherwise specified. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	sodium Chloride 0.9% IV bolus <i>Dose:</i> 1000 mL <i>Route:</i> Intravenous <i>Frequency:</i> Give IV over 1 hour one time PRN for hypotension due to presumed anaphylaxis. Notify provider if patient experiences a hypersensitivity reaction.
<input checked="" type="checkbox"/>	EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-Injector <i>Dose:</i> 0.3 mg <i>Route:</i> Intramuscular <i>Frequency:</i> Once PRN for anaphylaxis. Give IM one time for severe cardiovascular or respiratory symptoms (e.g. dyspnea, wheeze/bronchospasm, stridor, hypoxemia) of a suspected hypersensitivity reaction. Provider must be present upon given medication.

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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Page 3 of 3

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Nursing Orders

- Ensure CBC, AST and ALT, and Creatinine have been drawn within the last 8 weeks.
- If labs have not been drawn within 8 weeks, proceed with infusion and instruct patient to receive lab draw today.
- Notify provider if patient is more than 12 weeks overdue for labs.
- *Initial Dose Only:* Verify PPD or quantiFERON-TB assay for latent TB results are negative for TB.
- Perform assessment for toxicity and tolerance.
- Monitor for temperature greater than 100.4F, chills, pruritus, chest pain, blood pressure changes (notify MD if greater than 10% drop in systolic blood pressure or if patient is symptomatic), or dyspnea.
- For hypersensitivity: stop vedolizumab, give diphenhydramine and steroid as ordered.
- Review discharge medications, instructions, and future appointments.

References

vedolizumab® (ENTYVIO) injection for subcutaneous or intravenous use Prescribing Information. Revised April 2024.

Kaiser Permanente Infusion Locations

Please refer to the link below for the current list and contact information:

<https://wa-provider.kaiserpermanente.org/patient-services/ambulatory-infusion>

Provider Signature: _____ Date: _____

Printed Name: _____ Phone: _____ Fax: _____