KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Vedolizumab (ENTYVIO) – Induction only
Infusion Therapy Plan Orders

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 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 of the following:

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

Order Date: _____

Weight: _____kg

Diagnosis:

ICD-10 code *(REQUIRED):* _____

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) 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) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD

Note any changes to above regimen: _____

Pre-Meds

acetaminophen (TYLENOL) tablet

☑ *Dose:* 650 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to vedolizumab infusion. May also be given once as needed during infusion for achiness, headache, or fever.

cetirizine (ZYRTEC) tablet

☑ *Dose:* 10 mg *Route:* Oral *Frequency:* Once, at least 30 minutes prior to vedolizumab infusion (if not taken at home).

hydrocortisone sodium succinate (SOLU-CORTEF) injectable

☑ *Dose:* 50 mg *Route:* Intravenous *Frequency:* Once PRN, 30 minutes prior to vedolizumab infusion in addition to acetaminophen and cetirizine if patient still experiences symptoms with acetaminophen and cetirizine alone.

☐ Other: _____

Dose: _____ *Route:* Oral *Frequency:* Once, 30 minutes prior to vedolizumab infusion

Provider Signature: _____ **Date:** _____

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

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☐ No routine pre-medications necessary. Above pre-meds may be given if patient has reaction and requires pre-medications for future doses.

IV Line Care

☑ 0.9% sodium chloride infusion 250 mL
Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open
Start peripheral IV if no central line

PRN and HSR (Hypersensitivity Reaction) Medication

☑ Acetaminophen (TYLENOL) 325 mg tab. Take 2 tablets PO every 4 hours PRN for fever (greater than 100.4 F), myalgias, arthralgias or headache.

☑ Alteplase (CATHFLO ACTIVASE) Inj 2 mg INTRACATHETER PRN x 2 doses. 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.

☑ Diphenhydramine (BENADRYL) 50 mg Inj. Give IV push over 2 minutes one time, if needed for hives, rash, itching, flushing, and/or swelling in a suspected hypersensitivity reaction. May repeat one time, if needed. Notify provider if patient experiences a hypersensitivity reaction.

☑ Famotidine (PEPCID) (PF) Inj 20 mg. 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.

☑ methylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF). 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.

☑ Sodium Chloride 0.9% IV bolus 1,000 mL. Give IV over 1 hour, one time PRN for hypotension due to presumed anaphylaxis. Notify provider if patient experiences a hypersensitivity reaction.

☑ EPINEPHrine (Epi-Pen) 0.3 mg/0.3 mL IM Auto-injector. Give IM one time PRN for severe cardiovascular or respiratory symptoms (e.g., dyspnea, wheeze/bronchospasm, stridor, hypoxemia) of a suspected hypersensitivity reaction. Provider must be present upon giving medication.

Lab Review for Nursing

- Ensure CBC, AST and ALT 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.

Nursing Orders

- *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.

Kaiser Permanente Infusion Locations

Please refer to the link below for the current list:
https://wa-provider.kaiserpermanente.org/patient-services/ambulatory-infusion

Provider Signature: _____ **Date:** _____

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