KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Vedolizumab (ENTYVIO) – Induction + Maintenance
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 Schedule: Infuse vedolizumab at 0, 2, 6, then every 8 weeks. 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 1 month prior to initiation 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 x 2 doses, then every 4 weeks x 1 dose, then every 8 weeks thereafter.**
Infusion Rate: Infuse over 30 minutes
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 (if not taken at home). 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.

Provider Signature: _____ **Date:** _____

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

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

☐ 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

Infusion Reaction Meds

☑ albuterol (ACCUNEB) nebulizer solution
Dose: 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing

☑ diphenhydrAMINE (BENADRYL) injectable
Dose: 25 mg *Route:* Intravenous *Frequency:* Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector
Dose: 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify MD if administered.

☑ MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF).
Dose : 125 mg *Route* : IV push *Frequency:* Once PRN for hypersensitivity reaction. Notify MD if administered

Lab Review for Nursing

- Ensure CBC, AST, ALT, and Creatinine have been drawn within the last 16 weeks.
- If labs have not been drawn within the last 16 weeks, proceed with infusion and instruct patient to receive lab draw today.
- Hold infusion and notify provider if patient has not had labs drawn within the last 20 weeks.

Nursing Orders

- *Initial dose only:* Verify PPD or quantiFERON-TB assay for latent TB results are negative for TB.
- Monitor patient for hypersensitivity reaction: urticaria, dizziness, fever, rash, rigors, pruritus, nausea, flushing, hypotension, dyspnea, and/or chest pain.
- Monitor for signs and symptoms of infection such as fever (greater than 100 degrees F), chills, pruritis, sore throat, erythema, skins sores, and dysuria.
- Discontinue IV line when therapy complete and patient stabilized.

References

- ENTYVIO® Prescribing Information. Revised June 2022.

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3512 Phone: 425-502-3510

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-2104 Phone: 206-326-3109

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7106 Phone: 360-923-7164

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-324-7168 Phone: 509-241-2073

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-383-6262 Phone: 253-596-3666

Provider Signature: _____ **Date:** _____

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