

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_  
DOB: \_\_\_\_\_

Today's Date \_\_\_\_\_ Time \_\_\_\_\_

Diagnosis: \_\_\_\_\_  Other: \_\_\_\_\_

Age: \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ BSA (m<sup>2</sup>): \_\_\_\_\_

**ALLERGIES/Sensitivities:**  NKDA or  \_\_\_\_\_

**Start Date** (at least 1 wk from today): \_\_\_\_\_  **Urgent (Call Infusion Center)**

**Treatment Department:**  EHW OP Infusion

**Appointment**

**Requests:** Tolerance:  Use default, for chronic treatments order valid for 1 year

Appointment Request – Infusion – 2 hours Once on Week 0, 2, and 6

**Treatment Conditions** (Administer Treatment if):  Once on Day 1

Hepatitis B surface antigen and Hepatitis B core antibody NONREACTIVE (within 365 days)

Administer treatment if – Tuberculosis Test Negative (within 365 days)

*NOTE: TESTING SHOULD NOT DELAY TREATMENT*

Okay to treat. Include details here: \_\_\_\_\_

**Labs:** Lab (if selected) will be done as per appointment frequency selected above (unless specified)

C-Reactive Protein

Sedimentation Rate

CBC & Diff

Comprehensive Metabolic Panel

Quantiferon-TB Gold Plus

T-Spot Tuberculosis Test

Ferritin

Folate

Vitamin B12

Vitamin D25 Hydroxy

**Pre-Medications:**  Order will be done as per appointment frequency

Acetaminophen tablet 650 mg, oral, Once

DiphenhydrAMINE 25mg, once (choose one)  tablet, Oral  injection, IV

Famotidine 20 mg, once (choose one)  tablet, Oral  injection, IV

Loratadine tablet 10 mg, PO, Once

Hydrocortisone sodium succinate injection 100 mg, intravenous, once

**\*All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below\***

**Licensed Medical Professional**

**Attending Physician**

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Contact # \_\_\_\_\_

Contact # \_\_\_\_\_

[Place patient sticker here]

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_  
DOB: \_\_\_\_\_

**Supportive Care:**

Order will be done as per appointment frequency

- Sodium chloride 0.9% prime bag 250 ml  
250 ml, intravenous, at 0-999, PRN as needed, Prime Bag

**Medication:**

Week 0, 2, and 6

- Vedolizumab (Simponi Aria®) 300 mg in in NS 250 mL over 30 min  
Infuse over 30 minutes using low-protein binding 0.2 micron filter

**Emergency Medications**

Order will be done as per appointment frequency

- Hypersensitivity reaction protocol  
Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

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**Licensed Medical Professional**

Print Name: \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Contact # \_\_\_\_\_

**Attending Physician**

Print Name: \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_  
Contact # \_\_\_\_\_