YOURVANTAGE™ PROGRAM* PHYSICIAN REQUEST AND PATIENT CONTACT CONSENT FORM

Please ensure this form is filled out in its entirety to avoid delays in processing your request.

YOURVANTAGE™ PROGRAM | DESIGNED FOR YOU

Fax: 1-844-295-0198

PATIENT DEMOGRAPHICS

Last Name:	First Name:	Date of Birth:	Gender:	Preferred Language:
Street Address:		City:	Province:	Postal Code:
Home Tel.: Leave Message: ☐ Yes ☐ No	Cell Phone: Leave Message: ☐ Yes ☐ No	Alternate Contact Name/ Relationship/Tel. #:		

PHYSICIAN ORDERS

Dosage: ☐ **Loading Dose:** week 0, week 2, **ENTYVIO™ (vedolizumab) 300 mg IV** ☐ **Maintenance Dose:** week 6, **ENTYVIO™ (vedolizumab) 300 mg IV** and then every 8 weeks ☐ **Other:**	**Duration of Treatment:** ☐ 12 Months ☐ 6 Months ☐ 3 Months ☐ Other:

Weight (kg):	Allergies: ☐ Yes, Specify: ☐ No	Anticipated Start Date:

CLINIC SERVICES

Specimen Collection Required: ☐ Yes (If Yes, Please Attach Requisition) ☐ No

PRE-MEDICATIONS

☐ Methylpredinosolone 80 mg IV **OR** ☐ Dexamethasone 20 mg IV	☐ Diphenhydramine 50 mg PO at least 30 minutes pre-infusion
☐ Acetaminophen 650-1,000 mg PO at least 30 minutes pre-infusion	☐ Other:

This order form may act as prescription in jurisdictions which permit same. The pharmacy will contact prescribing physician if they require anything further to complete the Order or if Patient will be required to fill any prescription and bring same to the scheduled infusion.

INFUSION REACTION MANAGEMENT AND PRN MEDICATIONS

☐ I agree to the infusion reaction protocol as outlined on the reverse of this form to be used unless otherwise directed.

☐ I do not agree to the infusion reaction protocol as outlined on the reverse of this form and please follow my written directions below for the above-noted patient unless otherwise directed.

_____

_____

PRESCRIBING PHYSICIAN INFORMATION

Physician Name:	License #:	Tel.:	Fax:
Physician Address:	City:	Province:	Postal Code:
Physician Office Contact:	Physician Contact Tel.:	Physician Contact Fax:	
Prescribing Physician's Contact in Case of Emergency:	Alternate Contact Name/Tel. in Case of Emergency:		
Prescribing Physician Signature:		**Date:**	

As the prescribing physician, in signing this form I am aware of the approved Health Canada indication for ENTYVIO™ (vedolizumab). I have explained the risks and benefits of same to my patient and am using my medical judgment to prescribe ENTYVIO™ (vedolizumab).

As the patient, I confirm that I am requesting the ENTYVIO™ (vedolizumab) coordinator to contact me for enrolment into the YOURVANTAGE™ Program and to coordinate same with my prescribing physician.

Patient Printed Name:	**Patient Signature:**	**Date:**

My physician has advised me of the approved Health Canada indication for ENTYVIO™ (vedolizumab) and its risks and benefits as outlined above.

Legal Guardian Name/Relationship:	**Legal Guardian Signature:**	**Date:**

NEXT STEPS: **To the Prescribing Physician: The Program Coordinator will contact you with updates regarding your patient's status.**
To the Patient: The Program Coordinator will contact you with regard to your physician's prescription and the YOURVANTAGE™ Program.

*The YOURVANTAGE™ Program is a patient support program administered by Innomar Strategies Inc. (d/b/a AmerisourceBergen Specialty Canada), an independent service provider of Takeda Canada Inc. Service providers may change at the sole discretion of Takeda Canada Inc.

Standard Infusion Protocol AND Infusion Reaction Protocol for ENTYVIO™ (vedolizumab)

This "Standard Infusion Protocol" and "Infusion Reaction Protocol" is to be implemented in the absence of or as supplement to institutional-specific standard operating procedures in place for infusion and infusion-related reaction/anaphylaxis protocols and medical directives.

NOTE TO PRESCRIBING PHYSICIAN: Please modify or note any additional directives below and initial same.

Pre-Infusion

1. Perform pre-infusion checklist and physical assessment, incl. vitals signs (e.g., blood pressure, pulse, respiration rate, temperature and weight). Weight to be performed at first infusion only.
2. Contact the prescribing physician if the following occur:
   a. Signs and symptoms of infection;
   b. Receiving antibiotics not related to IBD treatment;
   c. Other concerns that may result in patients not passing the pre-infusion checklist/physical assessment.

During Infusion

1. Observe all patients until the infusion is complete; monitor vital signs before the infusion and at the end of the infusion.
2. If patient has had an infusion reaction in the past, monitor vital signs regularly during and post-infusion.

Post-Infusion

1. Monitor patients for as long as medically appropriate or as requested by a physician.
2. If patient has received sedating medications, extra caution should be exercised in evaluating patient's cognitive functions. Ensure an appropriate, responsible person is available to drive the patient home and is available to monitor patient at home as medically appropriate.
3. If a severe hypersensitivity or anaphylactic reaction, or other severe reaction occurs, give all pertinent information to emergency personnel, and inform patient's physician and all pertinent contacts.

Discharge

Inform the patient to seek medical attention should they experience rash; itching; swelling of lips, tongue, throat, or face; shortness of breath or trouble breathing; wheezing; dizziness; feeling hot; or palpitations; infections; symptoms of an infection including fever, chills, muscle aches, cough, shortness of breath, runny nose, sore throat, red or painful skin or sores on the body, tiredness, or pain during urination.

INFUSION REACTION PROTOCOL

Reaction level	Treatment*
Mild-Moderate	• Slow or interrupt ENTYVIO™ infusion and initiate appropriate treatment • Infuse normal saline (500-1,000 mL/hr) with primary tubing • If headache or fever, consider Acetaminophen 650 mg (adult max 1,000 mg/dose) • If pruritis/urticaria, consider diphenhydramine 25-50 mg PO/IV • Monitor vital signs regularly during and after infusion for as long as medically appropriate
Severe	• Stop administration of ENTYVIO™ immediately • Seek medical attention immediately • Infuse normal saline (500-1,000 mL/hr) with primary tubing • Maintain airway; oxygen prn • Diphenhydramine 25-50 mg IV • Hydrocortisone 100 mg IV or methylprednisolone 80 mg IV • Acetaminophen 650-1,000 mg (adult max 1,000 mg/dose) • Monitor vital signs regularly for as long as medically appropriate
Anaphylactic Shock	• Stop administration of ENTYVIO™ immediately • Seek medical attention immediately • Give all pertinent information to emergency personnel, inform patient's physician and all pertinent contacts • MD to confirm treatment plan moving forward

* The infusion reaction protocol is provided by way of an example only and does not provide a recommendation by the YOURVANTAGE™ Patient Support Program (the "Program"), its administrator Innomar Strategies Inc., d/b/a AmerisourceBergen Specialty Canada, or Takeda Canada Inc, or their affiliates or service providers . This protocol cannot guarantee any specific outcome, nor does it establish a standard of care, and it should not be considered inclusive of all proper approaches or methods, or exclusive of others. Treatment decisions must be made based upon the independent judgment of healthcare providers and each patient's individual circumstances. As a prescribing physician of ENTYVIO™, please ensure the Program and infusion site are informed of your patient directives and patient-specific requirements. Further, please consult the package inserts for all medications and treatments your patient is on for further information about doses, contraindications, and adverse effects before prescribing any medicine or treatment, including ENTYVIO™.

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