PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Bendamustine (Treanda®)

Patient's Surname	Given Name & Initials	Date of Birth _____ / _____ / _____ dd mm yyyy

Referring Physician

Patient's Height: _____ cm Weight: _____ kg BSA: _____ m^2	Cycle: ……

Pre-Medication (Only indicated if Grade 1 or 2 infusion reaction previously)

- ☐ Acetaminophen 650 mg PO 30-60 minutes pre-bendamustine
- ☐ Diphenhydramine 50 mg PO/IV 30-60 minutes pre-bendamustine
- ☐ Other ……

- Hydration/IV solution: NS TKVO on day 1 of each cycle
- Monitor vitals (BP, pulse, respiration, temperature) at outset and at 15 and 30 minutes
- Have anaphylactic kit available

Nurse to sign off indicating no infusion reaction on previous infusion : _____ (requires chart review)

Medication prescribed:

☐ **Bendamustine …….. mg (100 mg/m^2) IV in 500 mL NS over 30 minutes on Days 1 and 2 of a 28-Day Cycle (for CLL)**

Or ☐ **Bendamustine …….. mg (120 mg/m^2) IV in 500 mL NS over 60 minutes on Days 1 and 2 of a 21-Day Cycle (for NHL)**

Or ☐ **Bendamustine …….. mg (____ mg/m^2) IV in 500 mL NS over __ minutes on Days __ and __ of a ___-Day Cycle**

Scheduling (For Provis Use Only)

Day 1: _____ Day 2:_____

Referring Physician's Signature	_____ / _____ / _____ dd mm yyyy
Signature of Provis Physician	_____ / _____ / _____ dd mm yyyy

Fax completed form to: 416-532-3635

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