PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Cabazitaxel
(Jevtana ®)

Patient's Surname **Given Name & Initials**	**Date of birth** _____ / _____ / _____ dd mm yyyy
Referring MD/Oncologist	

Patient's Height: _____ cm Weight: _____ kg BSA: _____ m^2	Dose Reduction? Yes ☐ No ☐ Reason_____ Cycle: _____

Pre-Medication

☐ **Decadron** 8 mg po starting day prior to treatment. ****Treatment will be held if both parameters not met**

☐ Patient has taken at least 3 doses prior to treatment.

☐ Diphenhydramine 25 mg PO/IV

☐ Ranitidine 50 mg PO/IV

☐ **Other ……..**

☐ **Cabazitaxel** …… **mg (25 mg/m^2) IV in 250 cc NS over 1 hour (if dose ≤ 65 mg)**

or

☐ **Cabazitaxel** ……..… **mg (25 mg/m^2) IV in 500 cc NS over 1 hour (if dose > 65 mg)**

Non-PVC bag and non-PVC tubing to be used for all infusions.

(For Provis Use Only)

Tx ____: _____(date of Tx)

Scheduled Frequency:

Repeat every 3 weeks

(CBC will be required before each treatment.)

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

Repeat Order:

Provis requires a new medication order for each treatment.

Fax completed form to: 416-532-3635