P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

Onivyde® (Liposomal Irinotecan)

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

- ☐ **Dexamethasone** 12 mg PO prior to treatment.
- ☐ **Ondansetron** 8 mg PO prior to treatment.
- ☐ **Other** ……..

Note : Atropine 0.4 mg SC PRN for acute cholinergic symptoms (diarrhea, cramping, diaphoresis, flushing & lacrimation), to be prescribed as needed by Provis physician.

Ensure patient has ondansetron x 4 doses for post chemo management of nausea & vomiting.

☐ **Onivyde® (Liposomal Irinotecan) ……..mg (70 mg/m^2) IV in 500 cc NS over 90 minutes.**

or ☐ **Onivyde® (Liposomal Irinotecan) ……mg (…….. mg/m2) IV in 500 cc NS over 90 minutes.**

Note: Do NOT use in-line filter.

Scheduled Frequency: ☐ **Repeat every 2 weeks**

(CBC will be required before each tx.)

(For Provis Use Only)

Tx ____: _____(date of Tx)

Tx ____: _____(date of Tx)

Tx ____: _____(date of Tx)

Tx ____: _____(date of Tx/ N/A for q14days)

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 cycle

Fax completed form to: 416-532-3635

PROVIS

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