PROVIS

Provis Patient No.

MEDICATION ORDER FORM

RAMUCIRUMAB (Cyramza®)
(administered with Paclitaxel)

Patient's SurnameGiven 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

- ☐ Acetaminophen 650 mg PO 30-60 minutes pre-Ramucirumab
- ☐ Dexamethasone 20 mg IV 30-60 minutes pre- Ramucirumab
- ☐ Diphenhydramine 25 - 50 mg PO/IV 30-60 minutes pre- Ramucirumab
- ☐ Ranitidine 50 mg IV 30-60 minutes pre- Ramucirumab
- ☐ **Other ……..**

Q 3 Week Dosing:

☐ **Ramucirumab ……..mg (8 mg/kg) IV in 250 mL NS over 60 minutes x Days 1 & 15 (q 28 days)**

Or ☐ **Ramucirumab ……..mg (…..mg/kg) IV in 250 mL NS over 60 minutes x Days 1 & 15 (q 28days)**

Scheduled Frequency and notes:

Cycles q 28 (CBC will be required before each treatment.)

Note : Paclitaxel (80mg/m2) should be given on Days 1, 8, 15 of 28 day cycle

(For Provis Use Only)

Tx ____: _____(date of Tx)

Tx ____: _____(date of Tx)

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