PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Durvalumab (IMFINZI®)

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-Durvalumab
- ☐ Diphenhydramine 50 mg PO/IV 30-60 minutes pre-Durvalumab
- ☐ **Other ……..**

Q 2 Week Dosing:

☐ **Durvalumab ……..mg (10 mg/kg) IV in 100 mL NS over 60 minutes every 2 weeks**

Or ☐ **Durvalumab ……..mg (…..mg/kg) IV in 100 mL NS over 60 minutes every 2 weeks**

Notes:

*** Final concentration of Durvalumab 1 – 15 mg/mL**
Use a 0.2 – 1.2 micron filter - to be used for all infusions
CBC/Diff Renal Function and Liver Function Tests will be required before each 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