P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

OLARATUMAB (Lartruvo®)
(administered with Doxorubicin)

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-Olaratumab
- ☐ Dexamethasone 20 mg IV 30-60 minutes pre-Olaratumab
- ☐ Diphenhydramine 25 - 50 mg PO/IV 30-60 minutes pre-Olaratumab
- ☐ **Other ……………………………………………..**

Q 3 Week Dosing:

☐ **Olaratumab ……..mg (15 mg/kg) IV in 250 mL NS over 60 minutes x Days 1 & 8 (q 21 days)**

Or ☐ **Olaratumab ……..mg (…..mg/kg) IV in 250 mL NS over 60 minutes x Days 1 & 8 (q 21 days)**

Scheduled Frequency:

Cycles q 21 (CBC will be required before each treatment.)

(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