PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Atezolizumab (Tecentriq™)

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

- ☐ Acetaminophen 650 mg PO 30-60 minutes pre-Atezolizumab
- ☐ Diphenhydramine 50 mg PO/IV 30-60 minutes pre-Atezolizumab
- ☐ **Other ……..**

Q 3 Week Dosing:

☐ **Atezolizumab 1,200mg IV in 250 mL NS over 60 minutes (first dose)**
or
☐ **Atezolizumab _____mg IV in 250 mL NS over 60 minutes (first dose)**
and then,
subsequent doses IV over 30 minutes if well tolerated - every 3 weeks

Notes:

(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