P R O V I S

| Provis Patient No. |
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# MEDICATION ORDER FORM

## Enfortumab Vedotin (Padcev®)

| Patient's Surname | Given Name & Initials | Date of Birth<br>_______ / _______ / ___________<br>dd mm yyyy |
|---|---|---|

Referring Physician

| Patient's<br>Height: __________ cm<br><br>Weight: __________ kg<br><br>BSA: ____________ $m^2$ | Cycle: ............................................... |
|---|---|

**Pre-Medication (<u>Only indicated if Grade 1 or 2 infusion reaction previously</u>)**

- ☐ Acetaminophen 650 mg PO 30 minutes pre-enfortumab
- ☐ Diphenhydramine 50 mg PO/IV 30 minutes pre- enfortumab
- ☐ Other .................................

- Hydration/IV solution: NS TKVO on day 1 of each cycle
- Monitor vitals (BP, pulse, respiration, temperature) at outset and at 15 and 30 minutes
- Have anaphylactic kit available

Nurse to sign off indicating no infusion reaction on previous infusion : _______________ (requires chart review)

**Medication prescribed:**

☐ **Enfortumab Vedotin ………….. mg (1.25 mg/kg) IV in 100 mL NS over 30 minutes**
**Day 1, Day 8, Day 15 of a 28 day cycle**
For patients weighing > 100 kg, use 100 kg in calculation of the dose. Max dose = 125 mg

**Or** ☐ **Enfortumab Vedotin ………….. mg (______ mg/kg) IV in 100 mL NS over 30 minutes**
**Day 1, Day 8, Day 15 of a 28 day cycle**
**(for dose reduction related to peripheral neuropathy or neutropenia)**
For patients weighing > 100 kg, use 100 kg in calculation of the dose. Max dose = 125 mg

**Scheduling (For Provis Use Only)**

Tx1 Date: _________________________

Tx 2 Date:_________________________

Tx 3 Date:_________________________

**A new MOF will be required for each cycle**

| **Referring Physician's Signature** | ______ / ______ / ___________<br>dd mm yyyy |
|---|---|
| **Signature of Provis Physician** | ______ / ______ / ___________<br>dd mm yyyy |

**Fax completed form to: 416-532-3635**



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