P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

Trabectedin (Yondelis®)

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-Post Medication

* Note – Patient must have a central IV line**

- ☐ Dexamethasone 20mg IV 30 minutes pre-Trabectedin
- ☐ Ondansetron 8 mg PO 30-60 minutes pre-Trabectedin
- ☐ Ondansetron 8 mg PO q12h x 4 doses post Trabectedin (Prescribed by oncologist)
- ☐ **Other ……………………………………………..**

Q 3 Week or Q 4 Week Dosing:

☐ **Trabectedin ……..mg (1.5 mg/m^2) IV in 500 mL NS over 24 hours every ___ weeks**

Or ☐ **Trabectedin ……..mg (____ mg/m^2) IV in 500 mL NS over 24 hours every ___ weeks**

- **Note - the medication will be given via an ambulatory pump**

Q 3 Week Dosing (Given in conjunction with Caelyx):

☐ **Trabectedin ……..mg (1.1 mg/m^2) IV in 500 mL NS over 3 hours every 3 weeks**

Or ☐ **Trabectedin ……..mg (____ mg/m^2) IV in 500 mL NS over 3 hours every 3 weeks**

(complete bloodwork will be required before each treatment)

(For Provis Use Only)

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 treatment.

Fax completed form to:416-532-3635