PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Ipilimumab (Yervoy®)

Patient's Surname	Given Name & Initials	Date of Birth _____ / _____ / _____ dd mm yyyy

Referring Physician

Patient's Height: _____ cm Weight: _____ kg BSA: _____ m^2	Cycle: ……

Pre-Medication

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

- Hydration/IV solution: NS TKVO on day 1 of each cycle
- Monitor vitals (BP, pulse, respiration, temperature) every 15 mins. For the 1st hour or until stable and then every hour until infusion completed. Have an adverse reaction kit available. Keep IV line in and observe Pt for 1 hr after end of infusion. If complications occur during infusion, observe patient for 2 hrs. after the end of infusion. If Pt experiences transient fevers or rigors during infusion, STOP infusion and observe. Inform physician and treat as ordered. Once stable, restart infusion at ONE-HALF the previous rate.

Medication prescribed:

☐ **Ipilimumab ……..mg (3 mg/kg) IV in 100 mL NS over 90 minutes every 3 weeks.**

or

☐ **Ipilimumab ……..mg (1 mg/kg) IV in 50 mL NS over 30 minutes every 3 weeks.**

Scheduling (For Provis Use Only)

Tx 1: _____ Tx 2:_____

Tx 3:_____ Tx 4:_____

Referring Physician's Signature	_____ / _____ / _____ dd mm yyyy
Signature of Provis Physician	_____ / _____ / _____ dd mm yyyy

Fax completed form to:416-532-3635