PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Brentuximab Vedotin (Adcetris™)

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 (Only indicated if Grade 1 or 2 infusion reaction previously)

- ☐ Acetaminophen 650 mg PO 30 minutes pre-brentuximab
- ☐ Diphenhydramine 50 mg PO/IV 30 minutes pre- brentuximab
- ☐ 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:

☐ **Adcetris ………….. mg (1.8 mg/kg) IV in 100 mL NS over 30 minutes every three weeks**
For patients weighing > 100 kg, use 100 kg in calculation of the dose. Max dose = 180 mg

Or ☐ **Adcetris ………….. mg (1.2 mg/kg) IV in 100 mL NS over 30 minutes every three weeks (for dose reduction related to peripheral neuropathy or neutropenia)**
For patients weighing > 100 kg, use 100 kg in calculation of the dose. Max dose = 120 mg

Scheduling (For Provis Use Only)

Tx Date: _________________________

Referring Physician's Signature	______ / ______ / __________ dd mm yyyy
Signature of Provis Physician	______ / ______ / __________ dd mm yyyy

Fax completed form to: 416-532-3635

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