METRO INFUSION CENTER

Durvalumab (IMFINZI) for Lung and Bladder Cancer

Name
DOB
Diagnosis/Code /

Weight: kg
Call for weight change greater than 10% from baseline
No dose modifications required for any weight change

BSA N/A:
Mg/Kg dosing

Laboratory or Other Tests Related to Treatment:
CMP with each treatment
CBC with each treatment
Other:
Patient should have a TSH; at least every 3 cycles (call if these labs have not been ordered after 3 cycles)

Dosing Guidelines/Parameters: **Provider must select hold parameters that will trigger a call from the RN**

No hold for ANC/Plt
Hold and call provider for ANC: /Platelet:
Hold and call for LFT's 3 x ULN and/or Bilirubin 1.5x ULN
HHold and call for creatinine 1.5x ULN
No hold parameters

Hydration orders: Not Required

Premedication and Antiemetic Orders: Not Required (minimal emetogenic potential)

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN AND TOTAL DOSES
Durvalumab	**10 mg/kg**	**_____mg**	**As per Pharmacy**	**IVPB**	**60 min**	**Every 2 weeks**
Durvalumab	**-------------**	**1500mg**	**As per Pharmacy**	**IVPB**	**60 min**	Every 4 weeks Every 3 weeks

Date of first treatment:_____________________________/Subsequent treatments may be given +/- 2 days
This order is good for 1 year from the date ordered

Other:
Use inline low-protein binding in-line filter pore size f 0.2- 0.22 micron
Oral cancer treatment patient is taking: ___________________________________

Call referring provider for:
1. Rash
2. Diarrhea of 6/day
3. Elevated LFT's or creatinine as outline above
4. Severe SOB; pulse oximeter less than 90%
5. Severe fatigue or weight loss
6. Neurologic changes
7. Allergic reaction-will plan for premeds with subsequent cycles

Other reasons to call:

Date: Referring Provider: _________________________ (SIGNATURE REQUIRED) _________________________ (PRINTED NAME REQUIRED) Phone#_______________________