METRO INFUSION CENTER

Name: ______________________________
DOB:________________________________
Diagnosis/Code: ______________/_______
Cancer Stage:__________________________

Avelumab (Bavencio)

Weight: ______________________lb ______________________ kg

Call for weight change greater than 10% from weight listed on order
No dose modifications required for any weight change

BSA: N/A
Mg/Kg dosing

Patient Clearance: **Attach treatment Consent Form ☐**

Patient will be seen by Oncology Provider prior to every __________________ cycle and cleared for treatment (Metro staff will also review symptoms prior to each treatment)
Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/___________days

Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:

Will be done at referring office (Name and phone# of who to expect labs from):

☐ CMP with each treatment ☐ CBC with each treatment
☐ Other: ☐TSH

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

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

Hydration Orders: Not required

Premedication and Antiemetic orders:

This is the patients _____________treatment ☐Needs premeds (first 4 cycles only) ☐Does NOT need Premeds
☐Patient had a prior reaction premed required for all infusions

DRUG	DOSE	ROUTE	RATE	FREQUENCY, DAYS TO BE GIVEN
☐ Acetaminophen	650mg	PO	_____	30 minutes prior to treatment
☐ Diphenhydramine	25mg	___IVPB _____PO	20 minutes	30 minutes prior to treatment

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ **Avelumab (Bavencio)**	Flat Dosing	800mg	As Per Pharmacy	IVPB	60 minutes	Every 2 weeks
☐ **Avelumab (Bavencio)**		__________mg	As Per Pharmacy	IVPB		

Date of intended first treatment at Metro Infusion Center:____
Subsequent treatment may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Other: Administer using sterile, non-pyrogenic, low protein binding in-line filter (pore size of 0.2 micron)
Oral cancer treatment patient is taking: ____

Call referring provider for:

1. Rash
2. Elevated LFT's or creatinine as outline above
3. Severe fatigue or weight loss
4. Other reasons to call:

Diarrhea of 6/day
Severe SOB; pulse oximeter less than 90%
Neurologic changes

Date:

Referring Provider: _____________________ _______________________ Phone# __________________
SIGNATURE REQUIRED PRINTED NAME REQUIRED

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164.