METRO INFUSION CENTER

Ipilimumab (Yervoy)

Name: ______________________________________
DOB:______________________________________
Diagnosis/Code: __________________ /___________
Cancer Stage:_________________________________

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 prior to every ___________Cycle and cleared by Oncology provider 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: ☐ Patient should have a TSH; at least every 3 cycles.

Dosing Guidelines/Parameters: ***Provider must select hold 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: ☐ Not required (minimal emetogenic potential)

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐ Ipilimumab*	10 mg/kg	_______mg	As per Pharmacy	IVPB	30 mins	☐ Every 3 weeks x ______ doses
☐ Ipilimumab*	3 mg/kg	_______mg	As per Pharmacy	IVPB	30 mins	☐ Every 3 weeks x ________doses ☐ Every 12 weeks x ______doses
☐ Ipilimumab*	1 mg/kg	_______mg	As per Pharmacy	IVPB	30 mins	☐ Every 3 weeks x________ doses ☐ Every 6 weeks
☐ Ipilimumab*		_______mg	As Per Pharmacy	IVPB		☐ Every________ weeks x ______ doses

*When administered in combination with nivolumab, infuse nivolumab first followed by YERVOY on the same day
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:

If giving on the same day as nivolumab- give Nivolumab first then ipilimumab
Use inline non-pyrogenic, low protein binding in-line filter (pore size of 0.2-0.5 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. Allergic reaction – will plan for premeds with subsequent cycles
5. 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.