



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 changeBSA: 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	☐ IVP ☐ PO	2 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: of MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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