



METRO INFUSION CENTER

Name: _____

DOB: _____

Diagnosis/Code: _____ / _____

Cancer Stage: _____

Ipilimumab (Yervoy)

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 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 parametersHydration Orders: Not requiredPremedication 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
<input type="checkbox"/> Ipilimumab*	10 mg/kg	_____mg	As per Pharmacy	IVPB	30 mins	<input type="checkbox"/> Every 3 weeks x _____ doses
<input type="checkbox"/> Ipilimumab*	3 mg/kg	_____mg	As per Pharmacy	IVPB	30 mins	<input type="checkbox"/> Every 3 weeks x _____ doses <input type="checkbox"/> Every 12 weeks x _____ doses
<input type="checkbox"/> Ipilimumab*	1 mg/kg	_____mg	As per Pharmacy	IVPB	30 mins	<input type="checkbox"/> Every 3 weeks x _____ doses <input type="checkbox"/> Every 6 weeks
<input type="checkbox"/> Ipilimumab*		_____mg	As Per Pharmacy	IVPB		<input type="checkbox"/> 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:

- Rash Diarrhea of 6/day
- Elevated LFT's or creatinine as outline above Severe SOB; pulse oximeter less than 90%
- Severe fatigue or weight loss Neurologic changes
- Allergic reaction – will plan for premeds with subsequent cycles
- Other reasons to call: _____

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: MICreferral@metroinfusioncenter.com or fax to (866)507-1164.

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