


**IMFINZI® (DURVALUMAB) PRESCRIBER ORDER FORM**Fax completed form, insurance information, and clinical documentation to: **877-974-4845**

 option care health	<b>Patient Name:</b>		<b>Date of Birth:</b>	
	<b>Address:</b>			
	<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>

**Clinical Information**

<b>Primary Diagnosis Description:</b>	<b>ICD-10 Code: J9173</b>
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**Imfinzi®(durvalumab)Prescription**

Imfinzi® (durvalumab) Refill as directed x1 year

Stage III NSCLC: Weight < 30kg 10 mg/kg IV over 60 minutes every 2 weeks  
 Weight ≥ 30kg 10 mg/kg IV over 60 minutes every 2 weeks or 1500 mg over 60 minutes every 4 weeks

ES-SCLC: Weight ≥ 30kg 1500 mg IV over 60 minutes every 3 weeks prior to chemotherapy and then every 4 weeks as a single agent  
 Weight < 30kg 20 mg/kg IV over 60 minutes every 3 weeks in combination with chemotherapy, then 10 mg/kg every 2 weeks as a single agent \* (when administered with etoposide and carboplatin or cisplatin -not provided by Option Care Health) \*

**Ancillary Orders**

**Anaphylaxis Orders**

Anaphylaxis Kit > Required per Option Care Health Policy - Please complete Anaphylaxis Physician Order (FR-PC-036) provided.

**Pre-Medication Orders**

Acetaminophen 650 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for fever or mild discomfort.

Diphenhydramine 25mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions.

Other: \_\_\_\_\_

**IV Flush Orders**

Peripheral: NS 2 to 3 mL pre-/post-use.

PICC and Central Tunneled/Non-Tunneled: NS 5 to 10 pre-/post-use, 5 mL pre-lab draw and 10 ml post-lab draw.  
 Heparin (10 unit/mL) 5 mL or (100 unit/mL) post-use.  
 For maintenance, Heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.  
 Heparin (100 unit/mL) 3 to 5 mL post-use.  
 For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Valved Catheters: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.  
 For maintenance, NS 5 to 10 ml at least weekly

**Lab Orders**

No labs ordered at this time.

Other: \_\_\_\_\_

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.  
 Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

<b>Prescriber Signature:</b>	<b>Date:</b>
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**Prescriber Information**

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

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