IMFINZI® (DURVALUMAB) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		**Gender:**
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

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

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ PICC and Central Tunneled/Non-Tunneled: 0.9% Sodium Chloride 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: 0.9% Sodium Chloride 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: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.
For maintenance, 0.9% Sodium Chloride 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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

