


YERVOY® (IPILIMUMAB) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

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

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Yervoy® (Ipilimumab) Prescription

Yervoy® (Ipilimumab)

- Infuse 3 mg/kg IV over 90 minutes once every 3 weeks x 4 doses.
- Infuse 10 mg/kg IV over 90 minutes once every 3 weeks x 4 doses, then once every 12 weeks.
- Other: _____

Dispense quantity sufficient of Yervoy® 50 mg and/or 200 mg single dose vials for each dose.

Dose will be rounded to closest 50 mg.

Ancillary Orders

Pre-Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
- Other: _____

IV Flush Orders

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

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate 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.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

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

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