YERVOY® (IPILIMUMAB) PRESCRIBER ORDER FORM

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

option care health

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

Clinical Information

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

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:**	

