YERVOY® (IPILIMUMAB) 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:

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

☐ 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.

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.
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

