METRO INFUSION CENTER

Dostarlimab-gxly (Jemperli)

Name: ____
DOB: ____
Diagnosis/Code: ______________________/___________

Flat dosing

Laboratory or Other Tests Related to Treatment:

☐ CMP with each treatment
☐ CBC with each treatment
☐ Other: _____________________________________;
Patient should have a TSH; at least every ____________cycles (call if these labs have not been ordered at least every 4 cycles)

Dosing Guidelines/ Parameters: **Provider must select hold parameters that will trigger a call from the RN**

☐ No hold for ANC/Plt OR Call for ____
☐ Hold and call for LFT's 3 x ULN and/or Bilirubin 1.5x ULN
☐ Hold and call for creatinine 1.5x ULN
☐ Amylase 2 x ULN
☐ Lipase 2 x ULN
☐ No hold parameters
☐ Other: ____

Hydration Orders: ☐ Not Required

Premedication and Antiemetic Orders: ☐ Not Required (minimal emetogenic potential)

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVE AND TOTAL DOSES
☐ Dostarlimab-gxly (Jemperli)	Flat Dose	500 mg	As per pharmacy	IVPB	30 min	Every 3 weeks For doses 1-4
☐ Dostarlimab-gxly (Jemperli)	Flat Dose	1000 mg	As per pharmacy	IVPB	30 min	Every 6 weeks Dose 5 onward
☐						

Date of first treatment: _________________________________/subsequent treatments may be given +/- 2 days

This order is good for 1 year from the date ordered

Other:
Use inline non-pyrogenic, low-protein binding in-line filter (pore size of 0.2–0.22 micron)
Oral medications patient is on: ____

Call referring provider for:

1. Rash
2. Diarrhea of 6/day
3. Elevated LFT's or creatinine as outlined above
4. Severe SOB; pulse oximeter less than 90%
5. Severe fatigue or weight loss
6. Neurologic changes
7. Allergic reaction- will plan for premeds with subsequent cycles

Other reasons to call:

DATE	Referring Provider:_______________________ (SIGNATURE REQUIRED) ___________________________ (PRINTED NAME REQUIRED) Telephone_______________________

Send a referral via fax at 866-507-1164 or email to the bionurses@metroinfusioncenter.com