## MIC METRO INFUSION CENTER

SIGNATURE REQUIRED

DOB:

Diagnosis/Code:\_\_\_\_\_/\_\_

Name:

## Ipilumumab (Yervoy)

I (						
Weight:kg						<b>BSA:</b> N/A:
Call for weight change greater than 10 % from baseline						-
No dose modifications required for any weight change						Mg/Kg 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 3 cycles (call if these labs have not been ordered after 3 cycles)						
Dosing Guidelines/ Parameters:       Provider must select hold parameters that will trigger a call from the RN         No hold for ANC/Plt						
Hydration Orders: Not Required						
Premedication and Antiemetic Orders: Not Required (minimal emetogenic potential)						
Treatment Orders:						
DRUG	SE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVE AND TOTAL DOSES
🗌 Ipilumumab	10 mg/kg	mg	Dilute at 1- 2mg/ml	IVPB	90 min	Every 3 weeks
🗌 Ipilumumab	3 mg/kg	mg	Dilute at 1- 2mg/ml	IVPB	90 min	Every 3 weeks
🗌 Ipilumumab	1 mg/kg	mg	Dilute at 1- 2mg/ml	IVPB	30 min	Every 3 weeks
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 0.2-0.5 micron) Oral cancer treatment patient is taking:						
Call referring provider for:						
1. Rash						
2. Diarrhea of 6/day						
<ol> <li>Elevated LFT's or creatinine as outlined above</li> <li>Severe SOB; pulse oximeter less than 90%</li> </ol>						
<ol> <li>Severe sob; pulse oximeter less than 90%</li> <li>Severe fatigue or weight loss</li> </ol>						
6. Neurologic changes						
7. Allergic reaction- will plan for premeds with subsequent cycles						
Other reasons to call:						
DATE						
	Referring Provider: Telephone					

PRINTED NAME REQUIRED