



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: SMAVIPI

DOCTOR'S ORDERS		Ht _____ cm	Wt _____ kg
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form			
DATE:	To be given:	Cycle # _____ of 4	
Date of Previous Cycle: _____			
<input type="checkbox"/> Delay treatment _____ week(s) for: <input type="checkbox"/> Hepatotoxicity <input type="checkbox"/> Other Toxicity: _____			
May proceed with doses as written if within 96 hours AST or ALT less than or equal to 2.5 times the upper limit of normal, total bilirubin less than or equal to 1.5 times the upper limit of normal Proceed with treatment based on blood work from _____			
TREATMENT:			
ipilimumab 3 mg/kg x _____ kg = _____ mg IV in 50 to 250 mL NS over 1 hour 30 minutes using a 0.2 micron in-line filter.* * if no infusion reactions after 2 treatments, may infuse subsequent doses over 30 minutes			
RETURN APPOINTMENT ORDERS			
<input type="checkbox"/> Return in three weeks for Doctor and Cycle # _____			
<input type="checkbox"/> Last Treatment. Return in _____ week(s)			
CBC, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH prior to each treatment. During treatment: weekly telephone nursing assessment After treatment: every _____ weekly telephone nursing assessment for _____ weeks			
<input type="checkbox"/> serum cortisol <input type="checkbox"/> amylase <input type="checkbox"/> Other Tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.			
DOCTOR'S SIGNATURE:		SIGNATURE:	
		UC:	