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:

☐ Delay treatment _____ week(s) for:

☐ **Hepatotoxicity** ☐ **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

☐ Return in three weeks for Doctor and **Cycle # _____**

☐ 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

☐ **serum cortisol**
☐ **amylase**
☐ **Other Tests:**

☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: