A BC Cancer "Compassionate Access Program" request must be completed and approved prior to treatment.

**DOCTOR’S ORDERS**

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**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 ____________________________

Have Hypersensitivity Reaction Tray and Protocol Available.

**TREATMENT:**

ipilimumab 3 mg/kg x _________ kg = ______________ mg

IV in 100 mL NS over 1 hour 30 minutes using a 0.20 or 0.22 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:**

| UC: |

**SIGNATURE:**

Created: 1 November 2012   Revised: 1 May 2019