Bavencio (avelumab)

Order Form *cc*
Rev. 4/10/2023

Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

□ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ○ Yes *(please fax IA a copy)* ○ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

□ *(required)* Pathology/radiology results are attached.

Stage: ________________________________ Line of therapy: ________________________________

□ *(required)* **Immunotherapy consent obtained and faxed with order.**

Ordering provider is responsible for monitoring lab results including pregnancy screening, if applicable, during treatment. Please ensure timely notification if a treatment hold is indicated. **(833) 394-0600 option 6**

PRE-MEDICATION ORDERS

○ Diphenhydramine ○ PO or ○ IV □ 25mg or □ 50mg **OR** ○ Cetirizine 10 mg PO

○ Acetaminophen PO 650 mg

THERAPY ADMINISTRATION

Bavencio (avelumab) IV

Dose: 800 mg every 2 weeks

□ Patient's treatment regimen includes concurrent IV chemotherapy at another facility

Facility name: _____________________________________ Phone: ______________________________

Dose schedule: ○ Same day as chemo
○ ____ to ____ days BEFORE chemo
○ ____ to ____ days AFTER chemo

Date of last infusion if not at IA: ___________ RX Expiration Date: ___________

Additional Notes from Referring Office:

______________________________ ______________________________ ______________________

Provider Name (Print) **Provider Signature** **Date**