


**BAVENCIO® (AVELUMAB) PRESCRIBER ORDER FORM**Fax completed form, insurance information, and clinical documentation to: **877-974-4845**

	<b>Patient Name:</b> _____		<b>Date of Birth:</b> _____	
	<b>Address:</b> _____			
	<b>Phone:</b> _____	<b>Height:</b> _____	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b> _____

**Clinical Information**

<b>Primary Diagnosis Description:</b> _____	<b>ICD-10 Code:</b> J9023
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**Bavencio (avelumab) Prescription**

**Bavencio® (avelumab) Refill as directed x1 year**

Merkel Cell Carcinoma: Infuse 800mg IV over 60 minutes once every 2 weeks

Urothelial Carcinoma: Infuse 800mg IV over 60 minutes once every 2 weeks

Renal Cell Carcinoma: Infuse 800mg IV over 60 minutes once every 2 weeks (in combination with Axitinib -Not provided by Option Care Health)

Other: \_\_\_\_\_

**Ancillary Orders**

**Anaphylaxis Orders**

Anaphylaxis Kit >Required per Option Care Health Policy - Please complete Anaphylaxis Physician Order (FR-PC-036) provided.

**Pre-Medication Orders**

Acetaminophen 650 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for fever or mild discomfort.

Diphenhydramine 25mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions.

Other: \_\_\_\_\_

**IV Flush Orders**

Peripheral: NS 2 to 3 mL pre-/post-use.

PICC and Central Tunneled/ Non-Tunneled: NS 5 to 10 pre-/post-use, 5 mL pre-lab draw and 10 ml post-lab draw.  
Heparin (10 unit/mL) 5 mL or (100 unit/mL) 5 mL post-use.  
For maintenance, Heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.  
Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Valved Catheters: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.  
For maintenance, NS 5 to 10 ml at least weekly

**Lab Orders**

No labs ordered at this time.

Other: \_\_\_\_\_  
Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.  
Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescriber Information**

<b>Prescriber Name:</b> _____	<b>Phone:</b> _____	<b>Fax:</b> _____
<b>Address:</b> _____	<b>NPI:</b> _____	
<b>City, State:</b> _____	<b>Zip:</b> _____	<b>Office Contact:</b> _____

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