


# IMFINZI® (DURVALUMAB) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

 option care health	Patient Name:		Date of Birth:	
	Address:			
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

## Clinical Information

Primary Diagnosis Description:	ICD-10 Code: J9173
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## Imfinzi®(durvalumab)Prescription

Imfinzi® (durvalumab) Refill as directed x1 year

- Stage III NSCLC: Weight < 30kg 10 mg/kg IV over 60 minutes every 2 weeks  
Weight ≥ 30kg 10 mg/kg IV over 60 minutes every 2 weeks or 1500 mg over 60 minutes every 4 weeks
- ES-SCLC: Weight ≥ 30kg 1500 mg IV over 60 minutes every 3 weeks prior to chemotherapy and then every 4 weeks as a single agent  
Weight < 30kg 20 mg/kg IV over 60 minutes every 3 weeks in combination with chemotherapy, then 10 mg/kg every 2 weeks as a single agent \* (when administered with etoposide and carboplatin or cisplatin -not provided by Option Care Health) \*

## 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) 3 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:
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## Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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