

Doctor's Order Sheet  
**tebentafusp 68 mcg** Regimen:  
 Cycles 2+  
**ARIA Protocol Name:** tebentafusp Melanoma  
 Adult Chemotherapy - Medical Oncology  
 Unresectable or Metastatic Uveal Melanoma Therapy

Name: \_\_\_\_\_  
 HCN: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_



CC5530 0363 07/2023

Weight: \_\_\_\_\_ kg    Height: \_\_\_\_\_ cm    Body Surface Area (BSA) = \_\_\_\_\_

**Allergies:**  No Known

Date: DD/MONTH/YYYY    Planned Administration Date: DD/MONTH/YYYY  
 Cycle \_\_\_\_\_ of \_\_\_\_\_    **Cycle Duration: 21 days**    Date of previous cycle: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- CBC and differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

**PREMEDICATIONS:**

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

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**tebentafusp 68 mcg**

**IV** in 0.5 mL of 5% Human Albumin + 100 mL normal saline over 15 minutes on day 1, 8 & 15.

Patient must be monitored for a minimum of 60 minutes after the infusion is complete for Cycles 2 to 4. From Cycle 5 onwards, the observation period can be decreased to 30 minutes post infusion.

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Authorized Prescriber's Signature: \_\_\_\_\_ ID #: \_\_\_\_\_

Nurse's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.