

Doctor's Order Sheet
durvalumab 1500 mg Regimen
ARIA Protocol Name: durvalumab - Compassionate - Small Cell
 Adult Chemotherapy - Medical Oncology
 Limited Stage Small Cell Lung Cancer Therapy

Name: _____

HCN: _____

Date of Birth: _____



CC7040 0524 11 2024

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: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

durvalumab 1500 mg IV in 100 mL normal saline over 60 minutes on day 1

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.