

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor's Order Sheet

**tremelimumab 300 mg - durvalumab 20 mg/kg**

Regimen (Cycle 1)

**ARIA Protocol Name:** Tremelimumab 300 mg Durvalumab 20 mg/kg - HCC

Adult Chemotherapy - Medical Oncology

Unresectable Hepatocellular Carcinoma



CC7630 0583 07 2025

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

<b>Allergies:</b>		<input type="checkbox"/> <b>No Known</b>
Date: <u>DD/MONTH/YYYY</u>	Planned Administration Date: <u>DD/MONTH/YYYY</u>	
Cycle _____ of _____	<b>Cycle Duration: 28 days</b>	Date of previous cycle: <u>DD/MONTH/YYYY</u>
<b>MAY PROCEED WITH DOSES AS WRITTEN IF:</b>		
<ul style="list-style-type: none"> <li>• CBC with differential assessed.</li> <li>• LFTs and Bilirubin assessed.</li> <li>• Creatinine clearance assessed.</li> </ul>		
<b>PREMEDICATIONS:</b> None recommended		
<input type="checkbox"/> Other: _____		
<b>CHEMOTHERAPY (FOR HOSPITAL PHARMACY):</b>		
<input type="checkbox"/> <b>tremelimumab 300 mg</b>		
<b>IV</b> in 50 mL normal saline over 60 minutes on day 1		
<input type="checkbox"/> <b>durvalumab 20 mg/kg</b> X Weight (kg) = _____ <b>mg (max dose 1500 mg)</b>		
<b>IV</b> 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.