

Doctor's Order Sheet
ivosidenib 500 mg

Regimen

ARIA Protocol Name: ivosidenib 500 mg - Compassionate
Adult Chemotherapy - Medical Oncology
Cholangiocarcinoma/Biliary Tract Cancer

Name: _____

HCN: _____

Date of Birth: _____



CC9190 0639 03/2026

Allergies: No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
 Cycle of **Cycle Duration: 30 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- CBC with differential assessed
- Liver function assessed
- Creatinine clearance assessed
- Electrolytes (sodium, potassium, calcium, magnesium) assessed and any abnormalities corrected
- Heart rate corrected QT (QTc) less than 450 msec

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- ivosidenib 500 mg PO** daily on days 1 to 30
 Dose modification: **ivosidenib 250 mg PO** daily on days 1 to 30

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist.

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.