Infusion ASSOCIATES

Phone: 833-394-0600 Fax: 833-996-4888

Imfinzi IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

☐ **Immunotherapy consent obtained and faxed**

Ordering provider is responsible for monitoring lab results including pregnancy screening, if applicable, during treatment. Please ensure timely notification if a treatment hold is indicated. **(833) 394-0600 option 6**

Imfinzi (durvalumab) IV

(Please circle number of doses)

☐ Less than 30 kg: 10mg/kg every 2 weeks x 1 2 3 4 doses

☐ More than 30 kg: 10mg/kg every 2 weeks x 1 2 3 4 doses

☐ More than 30 kg: 1500mg every 4 weeks x 1 2 doses

☐ Patient's treatment regimen includes concurrent IV chemotherapy at another facility

Facility name_____Phone_____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _____