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

Bavencio 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 : _____, _____, _____

☐ Attach pathology/radiology results Stage:_____

Line of therapy: _____

☐ **Immunotherapy consent obtained and faxed with order**

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**

Pre-Medications:	**Diphenhydramine PO or IV**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No

Bavencio (avelumab) 800mg IV q2weeks

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

Facility name_____Phone_____

Dose schedule: ☐ Same day as chemo
☐ ____ to ____ days BEFORE chemo
☐ ____ to ____ days AFTER chemo

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 ☐TV/streaming ☐ Other: _____