PROVIS

Provis Patient No.

MEDICATION ORDER FORM

Bendamustine (Treanda®)

Patient's Surname	Given Name & Initials	Date of Birth ______ / ______ / __________ dd mm yyyy
Referring Physician		

Patient's Height: __________ cm Weight: __________ kg BSA: ____________ m^2	Cycle: …………………………………………

Pre-Medication (<u>Only indicated if Grade 1 or 2 infusion reaction previously</u>)

- ☐ Acetaminophen 650 mg PO 30-60 minutes pre-bendamustine
- ☐ Diphenhydramine 50 mg PO/IV 30-60 minutes pre-bendamustine
- ☐ Other ……………………………

- Hydration/IV solution: NS TKVO on day 1 of each cycle
- Monitor vitals (BP, pulse, respiration, temperature) at outset and at 15 and 30 minutes
- Have anaphylactic kit available

Nurse to sign off indicating no infusion reaction on previous infusion : _______________ (requires chart review)

Medication prescribed:

☐ **Bendamustine ………….. mg (100 mg/m^2) IV in 500 mL NS over 60 minutes on Days 1 and 2 of a 28-Day Cycle (for CLL)**

Or ☐ **Bendamustine ………….. mg (120 mg/m^2) IV in 500 mL NS over 60 minutes on Days 1 and 2 of a 21-Day Cycle (for NHL)**

Or ☐ **Bendamustine ………….. mg (____ mg/m^2) IV in 500 mL NS over __ minutes on Days __ and __ of a ___-Day Cycle**

Scheduling (For Provis Use Only)

Day 1: _________________________ Day 2:______________________

Referring Physician's Signature	______ / ______ / __________ dd mm yyyy
Signature of Provis Physician	______ / ______ / __________ dd mm yyyy

Fax completed form to: 416-532-3635

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