MIC METRO INFUSION CENT

# Nivolumab (Opdivo)

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

Weight: _____kg

☐ Call for weight change greater than 10 % from baseline
☐ No dose modifications required for any weight change

**BSA:** N/A

flat dosing or

mg/Kg

**Laboratory or Other Tests Related to Treatment:**
CMP with each treatment
☐ CBC with each treatment
Other: _____;
Patient should have a TSH; at least every 3 cycles (call if these labs have not been ordered after 3 cycles)

**Dosing Guidelines/ Parameters:** **Provider must select hold parameters that will trigger a call from the RN**
☐ No hold for ANC/Plt OR
☐ Hold and call provider for ANC: _____/Platelet: _____
☐ Hold and call for LFT's 3 x ULN and/or Bilirubin 1.5x ULN
☐ Hold and call for creatinine 1.5x ULN
☐ No hold parameters

**Hydration Orders:** ☐ Not Required

**Premedication and Antiemetic Orders:** ☐ Not Required (minimal emetogenic potential)

**Treatment Orders:**

| DRUG | DOSE CALCULATION | DOSE | SOLUTION AND VOLUME | ROUTE | RATE | FREQUENCY, DATES TO BE GIVE AND TOTAL DOSES |
|---|---|---|---|---|---|---|
| Nivolumab (Opdivo) | ☐ 240 mg | 240mg | 100ml NS | IVPB | 30 min | ☐ Every 2 weeks<br>☐ Every 3 weeks (primary mediastinal lymphoma) |
| Nivolumab (Opdivo) | ☐ 360 mg | 360mg | 100ml NS | IVPB | 30 min | Every 3 weeks |
| Nivolumab (Opdivo) | ☐ 480mg | 480mg | 100ml NS | IVPB | 30 min | Every 4 weeks |
| Nivolumab (Opdivo) | ☐ _____mg/kg | _____mg | 100ml NS | IVPB | 30 min | Every _____ weeks |
| | | | | | | |

Date of first treatment: _____/subsequent treatments can be +/- 2 days

This order is good for 1 year from the date ordered

**Other:**
Use inline non-pyrogenic, low protein binding in-line filter (pore size of 0.2 micrometer to 1.2 micrometer

Oral treatment patient is on: _____

**Call referring provider for:**

1. Rash
2. Diarrhea of 6/day
3. Elevated LFT's or creatinine as outlined above
4. Severe SOB; pulse oximeter less than 90%
5. Severe fatigue or weight loss
6. Neurologic changes
7. Allergic reaction- will plan for premeds with subsequent cycles

Other reasons to call:

| DATE | **Referring Provider:**_____ _____ **Telephone**_____ |
|---|---|
| | SIGNATURE REQUIRED PRINTED NAME REQUIRED |