

OPDIVO® (NIVOLUMAB) PRESCRIBER ORDER FORM

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Height: _____

 inches cm

Weight: _____

 lbs. kg**Clinical Information**

Primary Diagnosis Description: _____

ICD-10 Code: _____

Opdivo® (Nivolumab) Prescription

Opdivo® (Nivolumab) refill as directed x 1 year

- Infuse 240 mg IV over 30 minutes once every 2 weeks.
 Infuse 360 mg IV over 30 minutes once every 3 weeks.
 Infuse 480 mg IV over 30 minutes once every 4 weeks.
 Other: _____

Dose will be rounded to nearest whole vial, where applicable, for weight-based dosing.

Ancillary Orders**Anaphylaxis Orders**

- Anaphylaxis Kit >Required per Option Care Health Policy - Please complete Anaphylaxis Physician Order (FR-PC-036) provided.

Pre-Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for fever or mild discomfort.
 Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions.
 Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL
- PICC and Central Tunneled/ Non-Tunneled: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 5 mL or (100 unit/mL) post-use. For maintenance, heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.
- Valved Catheters: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, 0.9% Sodium Chloride 5 to 10 mL at least weekly.

Lab Orders

- No labs ordered at this time.
 Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed.

Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____

Date: _____

Prescriber Information

Prescriber Name: _____

Phone: _____

Fax: _____

Address: _____

NPI: _____

City, State: _____

Zip: _____

Office Contact: _____

Fax completed form, insurance information, and clinical documentation to:

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