

OPDIVO® (NIVOLUMAB) PRESCRIBER ORDER FORMFax completed form, insurance information, and clinical documentation to: **877-974-4845**

Patient Name:	Date of Birth:		
Address:			
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> 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: NS 2 to 3 mL pre-/post-use.
- PICC and Central Tunneled/ Non-Tunneled: NS 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: NS 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: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, NS 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:

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.