

OPDIVO® (NIVOLUMAB) PRESCRIBER ORDER FORM

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



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:
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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:

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