OPDIVO® (NIVOLUMAB) PRESCRIBER ORDER FORM

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

option care health

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:	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:**	

