



METRO INFUSION CENTER

Nivolumab and hyaluronidase-nvhy (OPDIVO QVANTIG)

Name: _____
 DOB: _____
 Diagnosis/Code: _____/_____
 Cancer Stage: _____

Flat dosing/no dose calculations

BSA: N/A
Mg/Kg dosing

Patient Clearance:

Attach treatment Consent Form

Patient will be seen by Oncology Provider prior to every _____ cycle and cleared for treatment (Metro staff will also review symptoms prior to each treatment)

Acceptable time frame from labs to day of infusion (Metro centers are not all open every day) 3 days/_____days

Laboratory or Other tests related to treatment that should be completed by referring office prior to clearance for Infusion:

Will be done at referring office (Name and phone# of who to expect labs from):

- CMP with each treatment
- CBC with each treatment
- TSH Other

Dosing Guidelines/Parameters: Provider must select parameters that will trigger a call from the Infusion staff

- Hold and call provider for ANC: _____ /Platelet: _____
- Hold and call for LFT's 3x or _____ 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 (list emetogenic potential)

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
<input type="checkbox"/> Nivolumab and hyaluronidase-nvhy (OPDIVO QVANTIG)	Flat Dose	600mg nivolumab/ 10,000 units Hyaluronidase	5ml	SQ- Abdomen or Thigh	Over 3-5 minutes	Every 2 weeks
<input type="checkbox"/> Nivolumab and hyaluronidase-nvhy (OPDIVO QVANTIG)	Flat Dose	900mg nivolumab/ 15,000 units Hyaluronidase	7.5ml	SQ- Abdomen or Thigh		Every 3 weeks
<input type="checkbox"/> Nivolumab and hyaluronidase-nvhy (OPDIVO QVANTIG)	Flat Dose	1200mg nivolumab/ 20,000 units Hyaluronidase	10ml	SQ- Abdomen or Thigh		Every 4 weeks

Date of intended first treatment at Metro Infusion Center: _____

Subsequent treatment may be given +/- 2 days or as otherwise specified:

This order is good for 1 year from the date ordered

Other:

Oral cancer treatment patient is taking: _____

Call referring provider for:

- | | |
|--|--|
| 1. Rash | Diarrhea of 6/day |
| 2. Elevated LFT's or creatinine as outline above | Severe SOB; pulse oximeter less than 90% |
| 3. Severe fatigue or weight loss | Neurologic changes |
| 4. Other reasons to call: | |

Date: _____ Referring Provider: _____ Phone# _____
 SIGNATURE REQUIRED PRINTED NAME REQUIRED

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: Intake@metroinfusioncenter.com or fax to (866)507-1164.