



# METRO INFUSION CENTER

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Diagnosis/Code: \_\_\_\_\_ / \_\_\_\_\_

Cancer Stage: \_\_\_\_\_

## Nivolumab (Opdivo)

Weight: \_\_\_\_\_ lb \_\_\_\_\_ kg

 Call for weight change greater than 10% from weight listed on order No dose modifications required for any weight changeBSA: 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 parametersHydration Orders:  Not requiredPremedication and Antiemetic orders:  Not required**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 (Opdivo)	Flat Dose	240mg	As Per Pharmacy	IVPB	30 minutes	Every 2 weeks
<input type="checkbox"/> Nivolumab (Opdivo)	Flat Dose	360mg	As Per Pharmacy	IVPB	30 minutes	Every 3 weeks
<input type="checkbox"/> Nivolumab (Opdivo)	Flat Dose	480mg	As Per Pharmacy	IVPB	30 minutes	Every 4 weeks
<input type="checkbox"/> Nivolumab (Opdivo)	1mg/kg	_____mg	As Per Pharmacy	IVPB	30 minutes	Every _____ Weeks
<input type="checkbox"/> Nivolumab (Opdivo)	3mg/kg	_____mg	As Per Pharmacy	IVPB	30 minutes	Every _____ Weeks
<input type="checkbox"/> Nivolumab (Opdivo)	6mg/kg	_____mg	As Per Pharmacy	IVPB	30 minutes	Every _____ 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:** Administer using sterile, non-pyrogenic, low protein binding in-line filter (pore size of 0.2 micrometer to 1.2 micrometer)

\*\*With Ipilimumab: administer OPDIVO first followed by Ipilimumab on the same day.

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                       |

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: [MICreferral@metroinfusioncenter.com](mailto:MICreferral@metroinfusioncenter.com) or fax to (866)507-1164.

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