MIC | METRO INFUSION CENTER

Nivolumab/Relatlimab-rmbw **(Opdualag)**

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

Flat dosing or mg/kg

Attach patient Consent Form ☐

Patient clearance:

Patient will be seen by Oncology Provider prior to every _____ cycle and cleared for treatment (MIC 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

☐ Patient should have a TSH; at least every 3 cycles. ☐Other: _____

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

☐ Hold and call provider for ANC: _____ /Platelet:_____

☐ Hold and call for LFT's 3x ULN and/or Bilirubin 1.5x ULN; If different note acceptable parameters:

☐ Hold and call for creatinine 1.5x ULN

☐ No hold parameters

Hydration Orders:

☐ Not required ☐ Other_____

Premedication and Antimetic orders:

☐ Not required (minimal emetogenic potential)

Treatment orders:

DRUG	DOSE CALCULATION Flat dosing	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVEN and TOTAL DOSES
☐Nivolumab/Relatimab (Opdualag)	Flat dosing	480 mg Nivolumab 160 mg Relatlimab	As per Pharmacy	IVPB	30 mins	☐ Every 4 weeks ☐ 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:

Use inline non-pyrogenic, low protein binding in-line filter (pore size of 0.2-1.2 micrometer)

Oral cancer treatment patient is taking: _____

Call referring provider for:

1. Rash
2. Elevated LFT's or creatinine as outline above
3. Severe fatigue or weight loss
4. Allergic reaction – will plan for premeds with subsequent cycles
5. Other reasons to call:_____

Diarrhea of 6/day
Severe SOB; pulse oximeter less than 90%
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 or fax to (866)507-1164.

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