

PROTOCOL CODE: HNAVIV

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DOCTOR'S ORDERS		Ht _____ cm Wt _____ kg BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
DATE:	To be given:	Cycle # _____
<input type="checkbox"/> Delay treatment _____ week(s) for: <input type="checkbox"/> Hepatotoxicity <input type="checkbox"/> Other Toxicity: _____ Day of treatment: <input type="checkbox"/> CBC/d, creatinine, alkaline phosphatase, ALT, Total bilirubin, LDH, sodium, potassium, TSH, glucose May proceed with doses as written if within 96 hours AST or ALT less than or equal to 3 times the upper limit of normal, total bilirubin less than or equal to 1.5 times the upper limit of normal, Creatinine less than or equal to 1.5 times the upper limit of normal and less than or equal to 1.5 times baseline. Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN / Pharmacist to confirm. For prior infusion reaction: <input type="checkbox"/> diphenhydramine 50 mg PO 30 minutes prior to treatment <input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to treatment <input type="checkbox"/> hydrocortisone 25 mg IV 30 minutes prior to treatment <input type="checkbox"/> Other:		
TREATMENT: nivolumab 3 mg/kg x _____ kg = _____ mg (max. 240 mg) every 2 weeks IV in 50 to 100 mL NS over 30 minutes using a 0.2 micron in-line filter.		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in two weeks for Doctor and Cycle # _____. <input type="checkbox"/> Return in four weeks for Doctor and Cycles # _____ and _____. Book chemo x 2 cycles. <input type="checkbox"/> Last Treatment. Return in _____ week(s).		
CBC and diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, glucose prior to each treatment. If clinically indicated: <input type="checkbox"/> ECG <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> lipase <input type="checkbox"/> ACTH <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> free T3 <input type="checkbox"/> free T4 <input type="checkbox"/> CXR <input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG <input type="checkbox"/> weekly telephone nursing assessment <input type="checkbox"/> Other Tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: