



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care

**PROTOCOL CODE: UHNAVIV4**

(Page 1 of 1)

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg
BSA _____ m <sup>2</sup>		
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #</b> _____
<input type="checkbox"/> Delay treatment _____ week(s) for: <input type="checkbox"/> <b>Hepatotoxicity</b> <input type="checkbox"/> <b>Other Toxicity:</b> _____ Day of treatment: <input type="checkbox"/> <b>CBC/d, creatinine, alkaline phosphatase, ALT, Total bilirubin, LDH, sodium, potassium, TSH, glucose</b> May proceed with doses as written if within <b>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.</b> Proceed with treatment based on blood work from _____		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN / Pharmacist to confirm. For prior infusion reaction: <input type="checkbox"/> <b>diphenhydrAMINE 50 mg</b> PO 30 minutes prior to treatment <input type="checkbox"/> <b>acetaminophen 325 to 975 mg</b> PO 30 minutes prior to treatment <input type="checkbox"/> <b>hydrocortisone 25 mg</b> IV 30 minutes prior to treatment <input type="checkbox"/> <b>Other:</b>		
<b>TREATMENT:</b> nivolumab 6 mg/kg x _____ kg = _____ mg (max. 480 mg) every 4 weeks IV in 50 to 100 mL NS over 30 minutes using a 0.2 micron in-line filter.		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>four weeks</b> for Doctor and Cycle # _____. <input type="checkbox"/> Return in <b>eight weeks</b> for Doctor and Cycles # ____ and _____. Book chemo x 2 cycles <input type="checkbox"/> Last Treatment. Return in _____ week(s).		
<b>CBC and diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, glucose</b> prior to each treatment. <input type="checkbox"/> <b>weekly telephone nursing assessment</b> <input type="checkbox"/> <b>serum cortisol</b> <input type="checkbox"/> <b>lipase</b> <input type="checkbox"/> <b>ACTH</b> <input type="checkbox"/> <b>FSH</b> <input type="checkbox"/> <b>LH</b> <input type="checkbox"/> <b>testosterone</b> <input type="checkbox"/> <b>estradiol</b> <input type="checkbox"/> <b>free T3</b> <input type="checkbox"/> <b>free T4</b> <input type="checkbox"/> <b>CXR</b> <input type="checkbox"/> <b>Other Tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>