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 and according to acceptable standards of care

PROTOCOL CODE: UHNAVNIV

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

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #** _____

☐ Delay treatment _____ week(s) for: ☐ **Hepatotoxicity** ☐ **Other Toxicity:** _____

Day of treatment:

☐ **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:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to treatment

☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to treatment

☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment

☐ **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

☐ Return in **two** weeks for Doctor and Cycle # _____.

☐ Return in **four** weeks for Doctor and Cycles # _____ and _____. Book chemo x 2 cycles.

☐ Last Treatment. Return in _____week(s).

CBC and diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, glucose prior to each treatment.

☐ **weekly telephone nursing assessment**

☐ **serum cortisol** ☐ **lipase** ☐ **ACTH** ☐ **FSH** ☐ **LH** ☐ **testosterone**

☐ **estradiol** ☐ **free T3** ☐ **free T4** ☐ **CXR**

☐ **Other Tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: