



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 and according to acceptable standards of care

PROTOCOL CODE: USMAJNIV

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

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 #:		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s)				
May proceed with doses as written if within 96 hours ALT less than or equal to 3 times the upper limit of normal, 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 X baseline.				
Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. For prior infusion reaction: <ul style="list-style-type: none"> <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 				
TREATMENT: <input type="checkbox"/> Repeat in two weeks 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 treatment x 2 cycles. <input type="checkbox"/> Last cycle. Return in _____ week(s) .				
CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH prior to each treatment If clinically indicated: <input type="checkbox"/> ECG <input type="checkbox"/> Chest X-ray <input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of child bearing potential <input type="checkbox"/> Free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> serum ACTH levels <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> Glucose <input type="checkbox"/> Weekly nursing assessment <input type="checkbox"/> Other consults: <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	