

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Opdivo[®] (nivolumab) Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:				
Patient Name:	Address:				
Date of Birth:	City, State, Zip:				
Height in inches:	Weight: LB or KG	Gender:	Allergies:	See list	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/> C34.90 - Non-Small Cell Lung Cancer	<input type="checkbox"/> C67.9 - Urothelial Carcinoma
<input type="checkbox"/> C81.90 - Classical Hodgkin Lymphoma	<input type="checkbox"/> C18.9 - Colorectal Carcinoma
<input type="checkbox"/> C15.9 - Gastroesophageal Carcinoma	<input type="checkbox"/> C16.9 - Gastric Carcinoma
<input type="checkbox"/> C43.9 - Melanoma	<input type="checkbox"/> C15.9 - Esophageal Carcinoma
<input type="checkbox"/> C45.0 - Unresectable Malignant Pleural Mesothelioma	<input type="checkbox"/> C64.____ - Renal Cell Carcinoma
<input type="checkbox"/> Other: _____	

REQUESTED DOCUMENTATION:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Recent CBC	THERAPY:	
			Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive nivolumab if experiencing severe (grade 3) immune-mediated adverse reactions.

MEDICATION:

OPDIVO[®] (nivolumab) IV given over 30 minutes diluted in 160mL NS or 5% Dextrose according to FDA labeling.

Premedication: _____
Premedication to be given 30 minutes prior to infusion unless otherwise noted above

DOSE/FREQUENCY:

240mg every 2 weeks
 400mg every 6 weeks
 Other: _____

SPECIAL ORDERS:

Prescriber is responsible for monitoring lab results/abnormalities including pregnancy screening, if applicable. Please ensure timely notification if a hold on therapy is indicated.

Refills x 12 months unless noted otherwise here:

NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted



Checklist for referrals to Palmetto Infusion: Fax referral to 1.800.521.9640

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com