Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

| Referral Status: | | MRN: | |
|---|---|---|---|
| ☐ New referral | ☐ Order change | ☐ 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 )

| | | | |
|---|---|---|---|
| ☐ | C34.90 - Non-Small Cell Lung Cancer | ☐ | C67.9 - Urothelial Carcinoma |
| ☐ | C81.90 - Classical Hodgkin Lymphoma | ☐ | C18.9 - Colorectal Carcinoma |
| ☐ | C15.9 - Gastroesophageal Carcinoma | ☐ | C16.9 - Gastric Carcinoma |
| ☐ | C43.9 - Melanoma | ☐ | C15.9 - Esophageal Carcinoma |
| ☐ | C45.0 - Unresectable Malignant Pleural Mesothelioma | ☐ | C64.____ - Renal Cell Carcinoma |
| ☐ | _____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 REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| 3 | Full medication list | | NEXT INFUSION DATE: |
| 4 | Tried and failed therapies | | **IF ORDER CHANGE:** |
| 5 | Recent CBC | | ☐ **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 preganncy screening, if applicable. Please ensure timely notification if a hold on threapy 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 | |