

PROTOCOL CODE: LYNIV

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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:				
<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:				
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 chemo x 2 cycles. <input type="checkbox"/> Last cycle. Return in _____ week(s).				
CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, electrolytes, 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"/> C-reactive protein <input type="checkbox"/> Creatinine kinase <input type="checkbox"/> troponin <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: