PROTOCOL CODE: SMAVALIPNI (Maintenance)

DOCTOR'S ORDERS

Wt _____kg

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

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

Date of Previous Cycle:

☐ Delay treatment _____ week(s) ☐ Delay for toxicity Type of toxicity_____

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:

☐ **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

IMMUNOTHERAPY: (select one)

☐ **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.

OR

☐ **nivolumab 6 mg/kg** x _____kg = _____ mg **(max. 480 mg) every 4 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 Cycle(s) # **_____ (**and **_____).**
☐ Book immunotherapy x 2 cycles (for treatment every 2 weeks option)
☐ Last cycle. Return in **_____ week(s).**

CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, creatine kinase (CK), glucose prior to each treatment

If clinically indicated: ☐ **ECG** ☐ **Chest X-ray**
☐ **serum HCG** or ☐ **urine HCG** (select one)– required for woman of child bearing potential
☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol**
☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**
☐ **Weekly nursing assessment**
☐ **Other consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: