

Doctor's Order Sheet  
**nivolumab 6 mg/kg Regimen**  
**ARIA Protocol Name:** Nivolumab 6 mg/kg  
 Adult Chemotherapy - Medical Oncology  
 Advanced Renal Cell Carcinoma

Name: \_\_\_\_\_  
 HCN: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_



CC3260 0137 09 2020

Weight: \_\_\_\_\_ kg    Height: \_\_\_\_\_ cm    Body Surface Area (BSA) = \_\_\_\_\_

<b>Allergies:</b>	<input type="checkbox"/> <b>No Known</b>
Date: <u>DD/MONTH/YYYY</u> Planned Administration Date: <u>DD/MONTH/YYYY</u> Cycle <u>      </u> of <u>      </u> <b>Cycle Duration: 28 days</b> Date of previous cycle: <u>DD/MONTH/YYYY</u>	
<b>MAY PROCEED WITH DOSES AS WRITTEN IF:</b>	
<ul style="list-style-type: none"> <li>• CBC and differential assessed.</li> <li>• LFTs and Bilirubin assessed.</li> <li>• Creatinine clearance assessed.</li> <li>• Thyroid function assessed.</li> </ul>	
<b>PREMEDICATIONS:</b> None recommended	
<input type="checkbox"/> Other: _____	
<b>CHEMOTHERAPY (FOR HOSPITAL PHARMACY):</b>	
<input type="checkbox"/> <b>nivolumab 6 mg/kg X Weight (kg) = _____ mg (maximum dose 480mg)</b>	
<b>IV</b> in 100 mL normal saline over 30 minutes on day 1	

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Authorized Prescriber's Signature: \_\_\_\_\_ ID #: \_\_\_\_\_

Nurse's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.