

Doctor's Order Sheet
**nivolumab 4.5 mg/kg -
 ipilimumab 1 mg/kg Regimen**
ARIA Protocol Name: nivolumab4.5 ipilimumab1 - MPM
 Adult Chemotherapy - Medical Oncology
 Unresectable Malignant Plueral Mesothelioma Treatment

Name: _____

HCN: _____

Date of Birth: _____



CC3900 0201 05 2022

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

Allergies:

No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
 Cycle _____ of _____ **Cycle Duration: 42 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- CBC and differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

nivolumab 4.5 mg/kg X Weight (kg) = _____ mg (maximum dose 360 mg)

IV in 100 mL normal saline over 30 minutes on days 1 and 22

ipilimumab 1 mg/kg X Weight (kg) = _____ mg

IV in 50 mL normal saline over 90 minutes on day 1

Cycles 3+ can be administered over 30 minutes if no adverse reaction

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.