

Doctor's Order Sheet
**nivolumab 240 mg -
ipilimumab 1 mg/kg Regimen**

ARIA Protocol Name: nivolumab 240 mg ipilimumab 1 mg/kg CRC -
Compassionate

Adult Chemotherapy - Medical Oncology

MSI-H or dMMR unresectable or metastatic colorectal cancer



CC7670 0587 08 2025

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

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
Cycle _____ of _____ **Cycle Duration: 21 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 240 mg**
 IV in 100 mL normal saline over 30 minutes on day 1
- ipilimumab 1 mg/kg X Weight (kg) = _____ mg**
 IV in 50 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.