

Doctor's Order Sheet

**nivolumab 480 mg Regimen**

**ARIA Protocol Name:** nivolumab 480 mg maintenance CRC - Compassionate Adult Chemotherapy - Medical Oncology

MSI-H or dMMR unresectable or metastatic colorectal cancer



CC7680 0588 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: 28 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 480 mg**

**IV** 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.