Local Infusion

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OPDIVO QVANTIG (NIVOLUMAB AND HYALURONIDASE-NVHY) INJECTION ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Mobile Number: _____ Patient Weight: _____kg
Allergies: _____
❑ Patient has known difficult venous access. Comments:_____
❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

❑ Description:_____ ICD 10: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____
Signature: _____ Date: _____
Contact Name: _____ Phone: _____ Fax: _____
Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:
❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Benadryl 25mg PO
❑ Famotidine 20 mg IV
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
OPDIVO Qvantig	❑ 300 mg/5,000 units every 2 weeks ❑ 600 mg/10,000 units every 4 weeks ❑ 600 mg/10,000 units every 2 weeks ❑ 1,200 mg/20,000 units every 4 weeks ❑ 900 mg/15,000 units with platinum-doublet chemotherapy on the same day every 3 weeks for **3 cycles** ❑ 900 mg/15,000 units with platinum-doublet chemotherapy on the same day every 3 weeks for up to **4 cycles** ❑ 900 mg/15,000 units every 3 weeks with cisplatin and gemcitabine on the same day for up to **6 cycles**	Subcutaneous injection

LABS / SPECIAL INSTRUCTIONS