INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Opdivo Qvantig *nivolumab and hyaluronidase-nvhy*

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) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

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

Order valid for 1 year from date of signature unless otherwise specified here: _____