NIVOLUMAB

Patient name_____ **Date** _____

This checklist is intended for nurses to use prior to dosing each patient and at any follow-up visits or calls with the patient to identify some of the signs and symptoms associated with adverse reactions related to treatment with nivolumab. Early identification of adverse reactions and intervention are an important part of the safe use of nivolumab.

Please note: this checklist is not meant to be all-inclusive.

IF THE PATIENT RESPONDS "YES" TO ANY OF THESE QUESTIONS, CONSULT WITH THE PATIENT'S HCP BEFORE ADMINISTERING NIVOLUMAB.

QUESTIONS	Response		Notes
GENERAL			
Are you having difficulty performing your normal activities?	Yes ❑	No ❑	
Have you had constant or unusual headaches?	Yes ❑	No ❑	
Have you felt drowsy or extremely tired?	Yes ❑	No ❑	
Have you felt dizzy or fainted?	Yes ❑	No ❑	
Have you had changes in mood or behavior, such as decreased sex drive, irritability, or forgetfulness?	Yes ❑	No ❑	
Have you felt cold?	Yes ❑	No ❑	
Have you gained or lost weight?	Yes ❑	No ❑	
Have you had hair loss?	Yes ❑	No ❑	
Has your voice gotten deeper?	Yes ❑	No ❑	
Have you noticed your skin or eyes are turning yellow?	Yes ❑	No ❑	
Are you experiencing increased thirst?	Yes ❑	No ❑	
Are you urinating more or less often than usual?	Yes ❑	No ❑	
Is your urine bloody, dark, or tea-colored?	Yes ❑	No ❑	
Do you bleed or bruise more easily than normal?	Yes ❑	No ❑	
Do you have swelling in your ankles?	Yes ❑	No ❑	
Have you had severe or constant muscle or joint pain?	Yes ❑	No ❑	
Have you had severe muscle weakness?	Yes ❑	No ❑	
Have you been running a fever?	Yes ❑	No ❑	
Have you had changes in your eyesight?	Yes ❑	No ❑	
Have you started taking any new medications (prescription, nonprescription, or herbal)? If yes, which and how often?	Yes ❑	No ❑	
PULMONARY			
Do you have a new cough or one that has worsened?	Yes ❑	No ❑	
Are you having chest pain?	Yes ❑	No ❑	
Are you having trouble breathing or shortness of breath?	Yes ❑	No ❑	
GASTROINTESTINAL			
Are you severely nauseous and/or vomiting?	Yes ❑	No ❑	
Do you have a loss of appetite or have you felt less hungry than usual?	Yes ❑	No ❑	
How many bowel movements are you having each day?			
• Is this different than normal? If yes, how?	Yes ❑	No ❑	
• Are your stools loose or watery, or do they have a foul smell?	Yes ❑	No ❑	
• Have you seen blood or mucus in your stools?	Yes ❑	No ❑	
• Are your stools dark, tarry, or sticky?	Yes ❑	No ❑	
Are you having painful bowel movements?	Yes ❑	No ❑	
Are you having pain or tenderness around your belly? If yes, where?	Yes ❑	No ❑	

QUESTIONS	Response		Notes
NEUROLOGICAL			
Have you experienced any periods of confusion?	Yes ❑	No ❑	
Have you lost consciousness at any point?	Yes ❑	No ❑	
Have you had any stiffness in your neck?	Yes ❑	No ❑	
Have you had any seizures?	Yes ❑	No ❑	
Have you had any sudden changes in your mood, your perception, your judgment, or your memory?	Yes ❑	No ❑	
SKIN			
Have you had a rash or itching?	Yes ❑	No ❑	
Have you had any skin blisters or ulcers in mouth or other mucous membranes?	Yes ❑	No ❑	
For your patients on nivolumab in combination with ipilimumab, consider asking the following questions:			
GENERAL			
Have you had eye pain or redness?	Yes ❑	No ❑	
Has your skin peeled?	Yes ❑	No ❑	
Are you having numbness or tingling in your hands or feet?	Yes ❑	No ❑	
Are you having unusual weakness of legs, arms, or face?	Yes ❑	No ❑	