

# YOUR OPDIVO<sup>®</sup> (nivolumab)/YERVOY<sup>®</sup> (ipilimumab) ACTION PLAN

(to be filled out by a member of your oncology team)

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
*Full Name* *Today's Date*

**Side effects discussed** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Key points** \_\_\_\_\_  
\_\_\_\_\_  
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## BMS RESOURCES

### Financial Assistance

- BMS Access Support  
1-800-861-0048  
<http://www.bmsaccesssupport.bmscustomerconnect.com/patient>

### Patient Resources

For more information about this therapy and support:

- Guide to Opdivo/Yervoy Combination Treatment  
<https://www.opdivo.com/servlet/servletFileDownload?file=00Pi000000o0a9ZEAQ>