MEDICINE INFORMATION

Nivolumab + ipilimumab (Opdivo and Yervoy)

Information for patients and caregivers about nivolumab + ipilimumab: treatment, monitoring, side effects and everyday care.

Nivolumab + ipilimumab at a glance

Nivolumab and ipilimumab are two immunotherapy medicines given together in selected cancer treatment plans. Opdivo is a brand of nivolumab; Yervoy is the brand of ipilimumab. They are normally given as separate intravenous infusions during the combination phase. The dose balance, visit pattern and duration depend on the particular plan.

This guide covers the two-drug immunotherapy combination and any planned nivolumab-only continuation. Keep your personal calendar with it. If another anticancer medicine is part of your prescription, you also need instructions for that medicine.

How the combination works

Nivolumab blocks PD-1 and ipilimumab blocks CTLA-4. These are checkpoints that help control immune-cell activity. Blocking two checkpoints can help the immune system recognise and attack cancer, but can also cause it to inflame healthy organs.

The combination is not simply two doses of the same treatment. Each component has a separate role, and the prescribed balance matters. A severe immune reaction is not evidence that treatment is more effective; it is a medical problem needing prompt assessment.

How the team decides whether it is suitable

Your oncologist considers the precise cancer type, stage, earlier treatment, relevant tumour tests and general health. This combination is used in several established settings, but eligibility and biomarker requirements differ. Ask which features of your cancer support the recommendation.

Discuss inflammatory bowel disease, other autoimmune conditions, lung or heart problems, previous organ or donor stem-cell transplantation and any serious reaction to earlier immunotherapy. The team also considers whether you can reach urgent care if symptoms develop between visits.

Approved uses by country

FDA (United States), EMA (European Union) and CDSCO (India).

Each treatment use is listed once. Eligibility can differ by country.

Approved by FDA, EMA and CDSCO

Advanced melanoma

- **US (FDA) · EU (EMA).** For adults and young people aged 12 years or older whose melanoma cannot be removed by surgery or has spread.
- **India (CDSCO).** For adults whose melanoma cannot be removed by surgery or has spread.
- **Advanced renal cell carcinoma.** As the first treatment for adults with intermediate- or poor-risk disease.

MSI-high or mismatch repair-deficient colorectal cancer

- **US (FDA).** MSI-high or mismatch repair-deficient colorectal cancer. For adults and young people aged 12 years or older whose colorectal cancer cannot be removed by surgery or has spread. An FDA-authorised test must confirm MSI-high or mismatch repair deficiency.
- **EU (EMA).** MSI-high or mismatch repair-deficient colorectal cancer, first treatment. For adults with cancer that cannot be removed by surgery or has spread to distant parts of the body.
- **EU (EMA).** MSI-high or mismatch repair-deficient colorectal cancer after chemotherapy. For adults with metastatic cancer who have had fluoropyrimidine-based combination chemotherapy.
- **India (CDSCO).** MSI-high or mismatch repair-deficient colorectal cancer. For adults and young people aged 12 years or older whose colorectal cancer cannot be removed by surgery or has spread.

First treatment for advanced hepatocellular carcinoma

Hepatocellular carcinoma. As first treatment for adults.

- **US (FDA) · India (CDSCO).** For liver cancer that cannot be removed by surgery or has spread.
- **EU (EMA).** For advanced liver cancer or liver cancer that cannot be removed by surgery.

Non-small-cell lung cancer with chemotherapy

- **US (FDA) · India (CDSCO).** Metastatic or recurrent non-small-cell lung cancer with chemotherapy. As first treatment for adults whose cancer has no EGFR or ALK genomic alterations. The two immunotherapy medicines are given with two cycles of chemotherapy that combines a platinum medicine with a second chemotherapy drug.
- **EU (EMA).** Metastatic non-small-cell lung cancer with chemotherapy. As first treatment for adults whose cancer has no sensitising EGFR mutation or ALK translocation. The two immunotherapy medicines are given with two cycles of platinum-based chemotherapy.
- **Malignant pleural mesothelioma.** As the first treatment for adults whose cancer cannot be removed by surgery.

Oesophageal squamous cell cancer

- **US (FDA) · India (CDSCO).** As the first treatment for adults with advanced cancer that cannot be removed by surgery or has spread.
- **US (FDA).** A PD-L1 result of at least 1 is required.
- **EU (EMA).** As the first treatment for adults with unresectable advanced, recurrent or metastatic disease. At least 1% of tumour cells must express PD-L1.

Approved by FDA and CDSCO

Metastatic non-small-cell lung cancer without chemotherapy

As the first treatment for adults whose tumour has no EGFR or ALK genomic alterations.

- **US (FDA).** PD-L1 expression must be at least 1%, confirmed by an FDA-authorised test.
- **India (CDSCO).** PD-L1 expression must be at least 1%, confirmed by a validated test.

Other FDA approvals

- **Unresectable or metastatic hepatocellular carcinoma after sorafenib.** For adults who have previously had sorafenib.

Before treatment starts

Your team will ask about autoimmune conditions, previous organ or donor stem-cell transplantation, lung or heart disease, infections and earlier cancer treatment. Mention previous severe reactions to any immunotherapy, even if you are now well. Tell them about pregnancy, breastfeeding, any possibility of pregnancy and whether you want to discuss fertility preservation before starting.

Bring a complete medicines list, including inhalers, eye drops, steroid creams, tablets, injections, vitamins and traditional or herbal remedies. A medicine taken only occasionally can still matter. Do not stop prescribed steroids or immune-suppressing treatment yourself; the team must weigh why you need them and how they fit with treatment.

Baseline tests usually include blood counts, kidney and liver function, blood sugar and thyroid function. Other hormone tests, heart tests or infection screening depend on your history and treatment plan. Record your usual bowel pattern, breathing, energy level and any existing rash. This makes it easier to identify a change rather than attributing everything to cancer.

Before leaving the first appointment, know how to reach your own hospital’s urgent oncology service, including outside clinic hours. Keep the treatment alert card or an up-to-date medicine record with you. A family member can help remember instructions and recognise changes you may not notice yourself.

How treatment is given

A trained nurse gives the medicines through a suitable intravenous line, with nivolumab before ipilimumab when both are due. Each infusion may take about 30 minutes under the relevant protocol, but preparation, assessment, line flushing and observation add time. Some product instructions or clinical circumstances require longer. Report infusion symptoms immediately.

Some common plans give both medicines every three weeks for up to four doses, then continue nivolumab alone. Other plans give nivolumab every two or three weeks and ipilimumab every six weeks. These patterns are not interchangeable. Your calendar should clearly mark which medicine is due on each date.

After an initial combination phase, intravenous nivolumab may be given every two or four weeks in appropriate schedules. The team determines total duration; do not assume that every indication has the same maximum number of months. If blood tests or symptoms make treatment unsafe, a dose may be delayed or treatment stopped rather than reduced.

A separate under-the-skin nivolumab formulation exists in some countries. Formulation eligibility depends on the exact label and phase: it must not automatically replace intravenous nivolumab while ipilimumab is being given. Certain authorised maintenance uses after intravenous combination treatment are distinct from concurrent administration. Ask the pharmacist to confirm any proposed switch.

Tell the nurse about flushing, itching, chills, dizziness, chest or back discomfort, breathlessness or swelling. Staff can interrupt treatment and manage a reaction. If the line hurts, leaks or becomes swollen, tell them immediately. For a missed appointment, phone the unit rather than changing your own schedule.

Monitoring and checking response

Before treatment, staff review symptoms and blood results to check that another dose is appropriate. Some immune problems first appear on a blood test, before you feel unwell. Thyroid, liver, kidney or glucose abnormalities may need repeat tests, additional investigations or another specialist’s advice.

Scans and, where appropriate, other disease measurements assess whether treatment is helping. Feeling well or having side effects cannot reliably tell you whether it is working. Occasionally immune inflammation complicates the interpretation of a scan; your oncologist decides whether a repeat scan or other assessment is appropriate. Worsening symptoms should still be reported promptly.

A dose may be delayed while a new symptom is investigated. Checkpoint antibodies are commonly withheld or stopped for significant toxicity rather than simply reduced to a smaller dose. This is a safety decision, not evidence that you have done anything wrong. The team balances cancer control with recovery and the risk of the same reaction happening again.

Common side effects and practical care

Side effects vary with the medicine, your health and any accompanying treatment. You may have several, a few or none. The effects described below can occur with this combination. Serious immune inflammation can sometimes begin with what seems like a mild everyday symptom. Frequency varies, so this guide does not attach a single percentage to effects across different treatment settings.

Tiredness and reduced energy

Plan demanding tasks for the time of day when you feel best, accept practical help and include gentle activity if you can. Rest is useful, but spending the entire day in bed can make weakness worse. A sudden increase in tiredness, dizziness or inability to manage normal activities needs assessment for anaemia, infection or hormone problems rather than being accepted as inevitable.

Skin rash and itching

Use a plain moisturiser, lukewarm water and comfortable clothing. Protect your skin from strong sunlight. Let the team know about a new rash; photographs can help show how it changes. Do not use a new medicated cream without checking. Blisters, peeling skin, mouth sores or a painful widespread rash need urgent help.

Loose stools or diarrhoea

Note how many times you pass stool compared with your normal pattern, whether it wakes you at night and whether there is pain, mucus or blood. Keep drinking unless you have a fluid restriction. Contact your team promptly for new or increasing diarrhoea. Do not repeatedly suppress it with over-the-counter medicines before the team has considered immune bowel inflammation.

Nausea, appetite changes and constipation

Small, regular meals and prescribed anti-sickness medicines may help. Ask for dietetic support if weight is falling or eating is difficult. Constipation can be related to other medicines or reduced activity; discuss an appropriate laxative rather than straining. Persistent vomiting, a swollen abdomen, severe pain or inability to keep fluids down requires urgent advice.

Muscle and joint discomfort

Gentle movement, pacing and the team’s recommended pain relief can help. Check before taking ibuprofen or similar anti-inflammatory medicines, especially with kidney problems or other treatment. New marked weakness, drooping eyelids, difficulty swallowing or dark urine is different from ordinary aching and needs urgent assessment.

Important side effects to recognise

Checkpoint treatment can make the immune system inflame healthy organs. Several organs can be affected together. Problems may appear during treatment or after it stops, and a symptom does not have to be dramatic to deserve attention.

Lung inflammation

New cough, breathlessness or chest discomfort can reflect inflammation called pneumonitis, infection or another problem. Contact the team promptly. Severe breathlessness, blue lips, collapse or difficulty speaking because of breathing requires emergency care.

Bowel and liver inflammation

Immune colitis can cause diarrhoea, cramps, blood or mucus, and occasionally serious bowel damage. Liver inflammation may initially show only on blood tests. Yellow eyes or skin, dark urine, right-sided upper abdominal pain or unusual bruising needs prompt assessment. Do not assume an existing digestive or liver condition explains a new change.

Hormone gland problems and diabetes

Thyroid, pituitary or adrenal inflammation can cause unusual tiredness, headache, feeling cold, weight changes, dizziness or altered mood. New excessive thirst and frequent urination can signal diabetes. Vomiting with marked thirst, deep or rapid breathing, confusion or severe weakness is an emergency. Some hormone deficiencies require long-term replacement even after the immune inflammation settles.

Kidney, heart, muscle and nerve problems

Reduced urine, blood in the urine or swelling may indicate kidney injury. Chest pain, palpitations, faintness, rapid weakness, swallowing difficulty, confusion or a seizure can signal serious heart or nervous-system effects. Heart, muscle and nerve inflammation can overlap. Do not wait for all the symptoms in a list to appear.

Eye problems, severe skin reactions and transplant complications

Eye pain, light sensitivity or new blurred vision needs urgent advice. Severe rash with blistering, peeling or mouth involvement needs immediate assessment. Checkpoint activation can also cause transplant rejection or complications around a donor stem-cell transplant. Tell every treating specialist that you have received this medicine.

How immune side effects are treated

Treatment may involve temporarily withholding immunotherapy, corticosteroids, hormone replacement or other specialist medicines. Severe reactions sometimes require hospital care and permanent discontinuation. Take the steroid taper exactly as prescribed; stopping abruptly can be dangerous. Early reporting often makes management more straightforward, but no one can promise that every effect will completely reverse.

The oncology team may involve an organ specialist. Bring your treatment alert card to emergency assessment; an emergency department may not have access to the cancer clinic’s records. Tell staff about current steroids and the last immunotherapy date. Do not wait for your next infusion appointment to report a problem.

When to get urgent medical help

Call local emergency services or go to the nearest emergency department immediately for severe breathing difficulty, severe chest pain, collapse, a seizure, major confusion, rapidly developing weakness, severe abdominal pain or a rapidly spreading blistering rash. Do not wait for a callback and do not drive yourself.

Contact your own oncology team or hospital’s urgent advice service promptly for new or worsening diarrhoea, cough, jaundice, reduced urine, persistent headache, visual change, excessive thirst, a new rash or a clear deterioration in how you feel. Mention the drug name and the date of your last dose, even if treatment has finished.

Follow your hospital’s temperature instructions. If you have not been given a threshold, seek urgent oncology advice for a temperature of 37.5°C (99.5°F) or above, below 36°C (96.8°F), shaking chills or feeling acutely unwell. Do not wait for fever if you are deteriorating. Measure temperature before taking fever-reducing medicine where possible, but do not delay seeking help.

Other medicines and vaccinations

Check new prescriptions, non-prescription medicines, supplements and herbal products with the cancer team or pharmacist. Avoid products marketed as “immune boosters”: they are not proven substitutes for treatment and can complicate safety assessment. Do not assume a natural product is harmless.

Steroids may be essential to treat immune side effects, despite the medicine’s aim of activating immunity. Never withhold necessary steroids because you are worried they will cancel the treatment. Equally, do not start leftover steroid tablets yourself. If you require hormone replacement or long-term steroids, carry the relevant alert information.

Discuss influenza, COVID-19 and other vaccines with the team. Non-live vaccines are often appropriate, but timing and response depend on the full treatment, particularly immune-suppressing medicines. Live vaccines need specific specialist approval. There is no single post-treatment vaccine waiting period that is correct for every checkpoint-treated patient.

Everyday life during treatment

Eating does not alter the dose of a medicine given by infusion or injection. Aim for adequate fluids and regular food, adjusting for nausea or diarrhoea, and follow any kidney, heart or diabetes advice already in place. Avoid restrictive diets or supplements promising to improve immune treatment response.

Work and exercise can continue if you feel able, with flexibility around appointments and fatigue. Start activity gently and reduce it when unwell. Do not drive if you are dizzy, sleepy, weak, visually affected or unable to concentrate. Premedicines and pain medicines can also impair driving. Sudden neurological symptoms require assessment, not simply a rest before driving again.

Discuss travel before booking, especially long journeys or places far from emergency care. Keep your treatment record, medicines list and enough prescribed medicines with you. Tell dentists and other clinicians about immunotherapy before procedures. Wash hands, avoid close contact with people who are clearly infectious and use food safety precautions; complete isolation is not usually necessary solely because you are receiving a checkpoint inhibitor.

Sex is generally possible if comfortable, with the contraception precautions below. Symptoms, dryness or fatigue may affect intimacy and can be discussed without embarrassment. Emotional support can help with uncertainty between scans; report persistent anxiety, poor sleep or low mood rather than carrying it alone.

Fertility, pregnancy and breastfeeding

If you could become pregnant, use effective contraception during the whole treatment course and for at least five months after the final nivolumab dose. US ipilimumab information specifies three months after its final dose; follow whichever applicable end date is later. Continuing nivolumab usually determines that later date. Have the team record your actual contraception end date, especially if one drug stops earlier. Pregnancy testing is needed before treatment when relevant.

Do not breastfeed during treatment. US nivolumab information advises avoiding breastfeeding for five months after its final dose, and US ipilimumab information specifies three months after its final dose. Follow the later applicable end date. Discuss the applicable product leaflets and a feeding plan with your team. Tell them immediately about possible pregnancy or contraceptive failure rather than waiting for a routine visit.

Effects on future fertility are not fully understood. Discuss preservation before treatment if future parenthood matters to you. Advice for a male partner is not automatically the same as the interval for someone who can become pregnant; ask for an individual plan.

After a pause or the end of treatment

Keep attending the follow-up appointments and tests recommended by your team. Immune side effects can start after the final dose, so continue to mention previous immunotherapy when seeking medical care. Keep your alert card or treatment summary accessible and tell emergency staff about the medicine even months later.

Continue prescribed hormone replacement, steroid tapering and other supportive treatment. Do not stop these because the anticancer infusion has finished. Follow the specified contraception and breastfeeding restrictions from the date of the final relevant dose. Recovery is individual; ask for rehabilitation, nutritional support or help returning to work if symptoms persist.

Frequently asked questions

Why are nivolumab and ipilimumab prescribed together?

They block different immune checkpoints, PD-1 and CTLA-4. In selected treatment settings the combination offers an additional treatment option, but also changes the risk of immune toxicity. Your oncologist should explain the expected benefit and trade-offs for your own diagnosis.

Does everyone have four combination doses?

No. Some plans use up to four initial combination doses followed by nivolumab alone. Other plans continue ipilimumab at longer intervals alongside nivolumab. Use the written schedule for your cancer rather than another patient’s calendar.

Why is my ipilimumab dose different from someone else’s?

The dose balance and intervals vary between indications. Some regimens use a higher ipilimumab dose relative to nivolumab and others use a lower dose. Weight, protocol and treatment phase matter. Different prescriptions do not by themselves indicate an error.

What is nivolumab maintenance?

It means nivolumab continues after the planned ipilimumab phase ends. It remains active anticancer treatment. You still need monitoring and should report new symptoms because earlier immune activation can continue and nivolumab can also cause immune effects.

Can I switch to a quick nivolumab injection?

The team must check your product, country and treatment phase. The US subcutaneous nivolumab product is not automatically a substitute during concurrent ipilimumab treatment; specified maintenance uses are different. A shorter injection must not be assumed equivalent to an intravenous prescription.

Is this the same as Opdualag?

No. Opdualag contains nivolumab plus relatlimab, not ipilimumab. These are different combinations with different schedules and evidence. Confirm the generic names if a prescription, billing sheet or appointment message appears inconsistent.

Do I need a PD-L1 or MSI test?

That depends on the cancer and treatment setting. Some decisions use PD-L1; colorectal-cancer selection can depend on mismatch-repair deficiency or high microsatellite instability. Your oncologist should explain the relevant test rather than applying one rule to every cancer.

Can I have treatment with an autoimmune condition?

It needs individual specialist assessment. Report conditions such as inflammatory bowel disease, rheumatoid arthritis or lupus and every medicine used for them. Do not stop immune-suppressing treatment yourself to make immunotherapy possible. The risks and potential benefit must be weighed together.

Why should I call about only a few extra loose stools?

A small change may be the beginning of immune bowel inflammation. Report the number above your normal pattern and any night-time stools, blood or cramps. Do not keep masking symptoms with over-the-counter remedies while waiting for the next clinic.

Can tiredness be a hormone problem?

Yes. New marked fatigue, dizziness, unusual headache, feeling cold or changes in thirst and urination may need hormone and blood-sugar tests. These symptoms are not automatically explained by cancer or stress, even when you have felt tired before.

What if I develop chest discomfort and muscle weakness together?

Seek urgent assessment. Rare heart, muscle and nerve inflammation can overlap. Severe chest pain, breathing trouble, difficulty swallowing or rapidly progressing weakness is an emergency; do not wait to see whether resting solves it.

Can side effects occur after ipilimumab ends?

Yes, including while nivolumab continues or after both medicines stop. Keep the date of your last doses and treatment alert card available. Tell emergency staff about both medicines even if you no longer attend the infusion unit.

Does a treatment pause mean the combination has failed?

A pause can allow investigation or recovery from a side effect. It does not by itself establish whether the cancer is responding. The team reviews scans, symptoms and safety before deciding whether one medicine, both, or neither should restart.

Will steroids stop the treatment from working?

The immediate priority is controlling a potentially harmful immune reaction. Steroids are recommended for many such reactions. Take prescribed treatment and tapering instructions seriously; do not omit essential doses because you want the immune response to stay strong.

Can thyroid tablets be needed permanently?

Yes. Some immune-related gland damage leaves lasting hormone deficiency. Replacement tablets may remain necessary even when the inflammation has settled and immunotherapy has finished. Keep follow-up blood tests and do not stop replacement medication without advice.

Is it safe to continue working?

It may be, depending on your symptoms and duties. Allow flexibility for visits and fatigue. Driving, heavy machinery and work far from medical help need extra thought if you have dizziness, visual changes or significant weakness. Seek assessment for new symptoms instead of simply pushing through.

Can I use an immune-boosting supplement?

No supplement is established as a way to improve the effect of this pair. Give the pharmacist the exact ingredients of anything you want to take. A product may affect other medicines or liver tests even if it is sold as natural.

How long will the entire course last?

Duration varies with the indication, protocol, response and side effects. A two-year limit applies in some settings but is not a universal rule for every nivolumab-ipilimumab prescription. Ask when duration will be reviewed and what would lead to stopping earlier.

What if I miss an appointment?

Contact the unit promptly so the prescribing team can revise the calendar. Do not assume that both drugs will be given at the next visit or that intervals can be shortened to catch up. Mention any illness that caused you to miss treatment.

When can pregnancy or breastfeeding be reconsidered?

Follow the written plan for both medicines. Nivolumab requires precautions extending for five months after its final dose, so the end of ipilimumab does not usually mark the end of precautions. Other medicines and your health may add further considerations.

Individual medicine guides

- Nivolumab
- Ipilimumab

Sources and review information

Sources checked: 8 October 2026. Read with your prescribed product leaflet and your hospital’s treatment plan.

Macmillan Cancer Support combination information

Cancer Research UK combination information

Bristol Myers Squibb Opdivo US prescribing information

Bristol Myers Squibb Yervoy US prescribing information

DailyMed Opdivo Qvantig current prescribing information

EMA Yervoy product information

Additional sources

Summary of Product Characteristics (SmPC)

- Opdivo (nivolumab): Summary of Product Characteristics - EMA product information, Annex I (PDF)

Regulatory references

- FDA prescribing information for intravenous Opdivo
- FDA prescribing information for Yervoy
- Bristol Myers Squibb India product information for Opdyta
- Bristol Myers Squibb India product information for Yervoi
- CDSCO approval for ipilimumab and nivolumab in oesophageal squamous cell cancer, 25 October 2024 (entry 103)

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