BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: UGOCXCATP

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

DOCTOR'S ORDERS

Ht__________**cm** **Wt**__________**kg** **BSA**__________**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment ______ week(s)

☐ **CBC & Diff**, **Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L,** creatinine **less than or equal to** 1.5 times the upper limit of normal ***and*** **less than or equal to** 1.5 times the baseline, **ALT less than or equal to 3 times the upper limit of normal, bilirubin less than or equal to 1.5 times the upper limit of normal**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** ____________________

Proceed with treatment based on blood work from ____________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ____________________.

☐ No prior infusion reaction to pembrolizumab: administer premedications as sequenced below

45 minutes prior to PACLitaxel:
dexamethasone 20 mg IV in 50 mL NS over 15 minutes
30 minutes prior to PACLitaxel:
diphenhydrAMINE 50 mg IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ Prior infusion reaction to pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab

45 minutes prior to pembrolizumab:
dexamethasone 20 mg IV in 50 mL NS over 15 minutes
30 minutes prior to pembrolizumab:
diphenhydrAMINE 50 mg IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to pembrolizumab

AND select **ONE** of the following:		
	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to CARBOplatin, and **ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to CARBOplatin

If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin
☐ **Other:**

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DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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DATE: **To be given:** **Cycle #:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

pembrolizumab 2 mg/kg x ______ kg = _________ mg **(max. 200 mg)**
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter*

PACLitaxel ☐ **175 mg/m²** x BSA = ___________ mg
☐ Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use Non DEHP tubing with 0.2 micron in-line filter*)

CARBOplatin AUC 5 x (GFR + 25) x = __________ mg
☐ Dose Modification: ________% = ________ mg
IV in 100 to 250 mL NS over 30 minutes

* use separate infusion line and filter for each drug

RETURN APPOINTMENT ORDERS

Return in ☐ **three** weeks for Doctor and Cycle _________

☐ Last Cycle. Return in three weeks for GOCXBP or GOCXBP6 (to continue pembrolizumab)

CBC & Diff, Platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH prior to each cycle.

If clinically indicated: ☐ **ECG** ☐ **Chest X-ray**

☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential

☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **Glucose**

☐ **GGT** ☐ **total protein** ☐ **albumin** ☐ **creatine kinase**

☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**

☐ **Weekly nursing assessment**

☐ **Other consults**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: