PROTOCOL CODE: USMAVTEB
Cycle 2+

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

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

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, creatinine, ALT, alkaline phosphatase, total bilirubin, LDH** day of treatment

For Cycle 2, may proceed with doses as written if within 48 hours **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, ALT less than or equal to 3 X ULN, total bilirubin less than or equal to 1.5 X ULN, and creatinine clearance greater than or equal to 30 mL/min**

For Cycle 3 onwards, may proceed with doses as written if within 48 hours of Day 1 **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, ALT less than or equal to 3 X ULN, total bilirubin less than or equal to 1.5 X ULN, and creatinine clearance greater than or equal to 30 mL/min**

Dose modification for: ☐ Other Toxicity: _____
Proceed with treatment based on blood work from _____

****Active transfusion consent must be in place prior to treatment****

Additional orders required if patient admitted to hospital for treatment. See protocol for details.
SCCRS orders required if patient admitted to hospital for treatment.

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

☐ **prochlorperazine** 10 mg PO or ☐ **metoclopramide** 10 mg PO prior to treatment

If required (for prior Grade 3 or higher CRS):

☐ **dexamethasone 4 mg** PO 30 to 60 minutes prior to treatment

☐ **acetaminophen 975 mg** PO 30 minutes prior to treatment

If required (for prior Grade 2 or higher skin toxicity):

☐ **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) 30 minutes prior to treatment

☐ **Other:**

****Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT:

tebentafusp 68 mcg IV in 100 mL NS with albumin 5% 0.5 mL over 15 minutes using 0.2 micron in-line filter on **Days 1, 8, and 15**

Observe for 1 hour post infusion. Vital signs prior to treatment and at 30 minutes and 60 minutes post infusion completion.

From Cycle 5 onwards, observation can be decreased to 30 minutes post infusion, with vital signs prior to treatment and at 30 minutes post infusion completion (if there have been no treatment interruptions greater than 2 weeks).

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

DATE:

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____. Book treatment on Days 1, 8, and 15.

Cycles 3 onwards, prior to each cycle: **CBC & Diff, platelets, creatinine, sodium, potassium, calcium, magnesium, phosphate, ALT, alkaline phosphatase, total bilirubin, LDH**

Cycles 3 onwards, if clinically indicated:

☐ **CBC & Diff, platelets, creatinine, sodium, potassium, calcium, magnesium, phosphate, ALT, alkaline phosphatase, total bilirubin, LDH** prior to Days 8 and 15

If clinically indicated:

☐ **Random glucose**
☐ **Other tests:**
☐ **Consults**
☐ **See general orders sheet for additional requests.**

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