

PROTOCOL CODE: UGOCXCATBP

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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:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets on 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, BP less than or equal to 150/100, and urine dipstick for protein negative or 1+. Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. <input type="checkbox"/> No prior infusion reaction to pembrolizumab: administer premedications as sequenced below <u>45 minutes prior to PACLitaxel:</u> dexamethasone 20 mg IV in 50 mL NS over 15 minutes <u>30 minutes prior to PACLitaxel:</u> 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) <input type="checkbox"/> Prior infusion reaction to pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab <u>45 minutes prior to pembrolizumab:</u> dexamethasone 20 mg IV in 50 mL NS over 15 minutes <u>30 minutes prior to pembrolizumab:</u> 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) <input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to pembrolizumab				
AND select ONE of the following:	<input type="checkbox"/> ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin			
If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> Other:				
Continued on page 2				
DOCTOR'S SIGNATURE:				SIGNATURE: UC:

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DOCTOR'S ORDERS

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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.

Blood pressure measurement pre-bevacizumab dose.

bevacizumab **15 mg/kg** or _____ mg/kg (*select one*) x _____ kg = _____ mg

IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour).

(Blood pressure measurement post-bevacizumab infusion for first 3 cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
bevacizumab		

* use separate infusion line and filter for each drug

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<p>DATE: _____ Page 3 of 3</p>	
<p>RETURN APPOINTMENT ORDERS</p>	
<p>Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in three weeks for GOCXBP or GOCXBP6 (to continue pembrolizumab with or without bevacizumab)</p>	
<p>CBC & Diff, Platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle.</p> <p><input type="checkbox"/> 24 hr urine for total protein within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein</p> <p><input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to next cycle</p> <p>If clinically indicated: <input type="checkbox"/> ECG <input type="checkbox"/> Chest X-ray</p> <p><input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of child bearing potential <input type="checkbox"/> Free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> Glucose <input type="checkbox"/> GGT <input type="checkbox"/> total protein <input type="checkbox"/> albumin <input type="checkbox"/> creatine kinase <input type="checkbox"/> serum ACTH levels <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> Weekly nursing assessment <input type="checkbox"/> Other consults <input type="checkbox"/> See general orders sheet for additional requests.</p>	
<p>DOCTOR'S SIGNATURE:</p>	<p>SIGNATURE:</p> <p>UC:</p>