

**PROTOCOL CODE: BRPCWTAC**

(Page 1 of 3)

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>					
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>			
Date of Previous Cycle: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, platelets</b> day of treatment					
On Day 1: may proceed with doses as written if within 48 h: <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 90 x 10<sup>9</sup>/L , 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, 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.</b>					
On Days 8 and 15: may proceed with doses as written if within 24 h: <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 90 x 10<sup>9</sup>/L</b>					
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____					
Proceed with treatment based on blood work from _____					
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.					
<b>CYCLE # 1 to 8</b> (pembrolizumab premedications)					
For prior pembrolizumab infusion reaction (and receiving PACLitaxel premedications):					
<input type="checkbox"/> Give PACLitaxel premedications prior to pembrolizumab infusion					
For prior pembrolizumab infusion reaction (if <b>not</b> receiving PACLitaxel premedications):					
<input type="checkbox"/> <b>diphenhydrAMINE 50 mg</b> PO 30 minutes prior to treatment					
<input type="checkbox"/> <b>acetaminophen 325 to 975 mg</b> PO 30 minutes prior to treatment					
<input type="checkbox"/> <b>hydrocortisone 25 mg</b> IV 30 minutes prior to treatment					
<input type="checkbox"/> <b>CYCLE # 1 to 4</b>					
<b>45 Minutes Prior to PACLitaxel:</b>					
<b>dexamethasone 10 mg</b> IV in NS 50 mL over 15 minutes					
<b>30 Minutes Prior to PACLitaxel:</b>					
<b>diphenhydrAMINE 25 mg</b> IV in NS 50 mL over 15 minutes and <b>famotidine 20 mg</b> IV in NS 100 mL over 15 minutes (Y-site compatible)					
<input type="checkbox"/> No premedication to PACLitaxel required (see protocol for guidelines)					
If <b>not</b> receiving IV dexamethasone for PACLitaxel, give: <b>dexamethasone</b> <input type="checkbox"/> <b>8 mg</b> or <input type="checkbox"/> <b>12 mg</b> (select one) <b>PO 30 to 60 minutes</b> prior to CARBOplatin					
<b>ondansetron 8 mg</b> PO 30 minutes prior to CARBOplatin					
<input type="checkbox"/> <b>CYCLE # 5 to 8</b>					
<b>dexamethasone</b> <input type="checkbox"/> <b>8 mg</b> or <input type="checkbox"/> <b>12 mg</b> (select one) <b>PO 30 to 60 minutes</b> prior to treatment and <b>select ONE</b> of the following:					
<input type="checkbox"/>	<b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to treatment				
<input type="checkbox"/>	<b>aprepitant 125 mg</b> PO 30 to 60 minutes prior to treatment <b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to treatment				
<input type="checkbox"/>	<b>netupitant-palonosetron 300 mg-0.5 mg</b> PO 30 to 60 minutes prior to treatment				
If additional antiemetic required:					
<input type="checkbox"/> <b>OLANzapine</b> <input type="checkbox"/> <b>2.5 mg</b> or <input type="checkbox"/> <b>5 mg</b> or <input type="checkbox"/> <b>10 mg</b> (select one) <b>PO 30 to 60 minutes</b> prior to treatment					
<input type="checkbox"/> <b>Other:</b>					
<b>*** SEE PAGE 2 FOR CHEMOTHERAPY ORDERS ***</b>					
<b>DOCTOR'S SIGNATURE:</b>					<b>SIGNATURE:</b>
					<b>UC:</b>

**PROTOCOL CODE: BRPCWTAC**

(Page 2 of 3)

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>			
<b>**Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4**</b>					
<p><b>TREATMENT:</b></p> <p><input type="checkbox"/> <b>CYCLE # _____ (Cycle 1-4)</b></p> <p><b>pembrolizumab 2 mg/kg</b> x _____ kg = _____ mg (<b>max. 200 mg</b>)          IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter* <b>Day 1 only</b></p> <p><b>PACLitaxel</b> <input type="checkbox"/> <b>80 mg/m<sup>2</sup></b> OR <input type="checkbox"/> _____ <b>mg/m<sup>2</sup></b> (select one) x BSA = _____ mg  <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m<sup>2</sup> x BSA = _____ mg          IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour on <b>Days 1, 8 and 15</b> (use non-DEHP tubing with 0.2 micron in-line filter*)</p> <p><b>CARBOplatin AUC 1.5 x (GFR + 25)</b> = _____ mg  <input type="checkbox"/> Dose Modification: _____ % = _____ mg          IV in 50 to 250 mL NS over 30 minutes on <b>Days 1, 8 and 15</b></p> <p>* Use separate infusion line and filter for each drug</p> <p><b><u>OR</u></b></p> <p><input type="checkbox"/> <b>CYCLE # _____ (Cycle 5-8)</b></p> <p><b>pembrolizumab 2 mg/kg</b> x _____ kg = _____ mg (<b>max. 200 mg</b>)          IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter</p> <p><b>DOXOrubicin 60 mg/m<sup>2</sup></b> x BSA = _____ mg  <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m<sup>2</sup> x BSA = _____ mg          IV push</p> <p><b>cyclophosphamide 600 mg/m<sup>2</sup></b> x BSA = _____ mg  <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m<sup>2</sup> x BSA = _____ mg          IV in 100 to 250 mL NS over 20 minutes to 1 hour</p>					
<b>DOCTOR'S SIGNATURE:</b>					<b>SIGNATURE:</b>
					<b>UC:</b>

**PROTOCOL CODE: BRPCWTAC**

(Page 3 of 3)

<b>DOCTOR'S ORDERS</b>	
DATE:	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ (Book chemo room weekly x 3 for cycles 1-4; book chemo room every three weeks for cycles 5-8, cycle 5 to start week 13)	
<input type="checkbox"/> Last Cycle. Return in <b>three</b> weeks for BRAJPEM (to continue single agent pembrolizumab)	
<input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<p><u>Cycles 1 to 4:</u>  <b>CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH</b> prior to each cycle.</p> <p><b>CBC &amp; Diff, Platelets, creatinine</b> prior to treatment on Days 8 and 15.</p> <p><u>Cycles 5 to 8:</u>  <b>CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH</b> prior to each cycle.</p> <p>If clinically indicated: <input type="checkbox"/> ECG    <input type="checkbox"/> Chest X-ray  <input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of child bearing potential  <input type="checkbox"/> GGT   <input type="checkbox"/> estradiol   <input type="checkbox"/> FSH   <input type="checkbox"/> LH   <input type="checkbox"/> glucose  <input type="checkbox"/> Free T3 and free T4    <input type="checkbox"/> lipase   <input type="checkbox"/> morning serum cortisol   <input type="checkbox"/> creatine kinase  <input type="checkbox"/> serum ACTH levels   <input type="checkbox"/> testosterone  <input type="checkbox"/> Weekly nursing assessment  <input type="checkbox"/> Other tests:  <input type="checkbox"/> Consults:  <input type="checkbox"/> See general orders sheet for additional requests.</p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>