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: GOCXBP**



## 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)

May proceed with doses as written if within 96 hours 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,** and, if using bevacizumab, if within 96 hours **BP less than or equal to 150/100, and Day 1 urine dipstick for protein negative or 1+**

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

**PREMEDICATIONS:** Not usually required.

If ordered, patient to take own supply. RN/Pharmacist to confirm_________________________________

For prior pembrolizumab infusion reaction:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to treatment
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to treatment
☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment

**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

If using bevacizumab:

☐ **bevacizumab 15 mg/kg** x _________ kg = _________ mg
IV in 100 to 250 mL NS over 30 minutes.

(Blood pressure measurement prior to bevacizumab)

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 | | |

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

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: GOCXBP**



<table>
<tr><td colspan="2">DATE:</td></tr>
<tr><td colspan="2">RETURN APPOINTMENT ORDERS</td></tr>
<tr><td>Return in <u>three</u> weeks for Doctor and Cycle _____.<br>☐ Last cycle. Return in ______ weeks.</td><td></td></tr>
<tr><td>CBC and differential, platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH prior to each cycle<br><br>If patient on bevacizumab:<br>Dipstick Urine or laboratory urinalysis for protein prior to each bevacizumab treatment<br><br>☐ 24-hour 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<br><br>☐ INR weekly ☐ INR prior to next cycle<br><br>If clinically indicated: ☐ ECG ☐ Chest X-ray<br><br>☐ serum HCG or ☐ urine HCG – required for woman of child bearing potential<br>☐ Free T3 and free T4 ☐ lipase ☐ morning serum cortisol<br>☐ Glucose ☐ GGT ☐ total protein ☐ albumin ☐ creatine kinase<br>☐ serum ACTH levels ☐ testosterone ☐ estradiol ☐ FSH ☐ LH<br>☐ Weekly nursing assessment<br>☐ Other consults<br>☐ See general orders sheet for additional requests.</td><td></td></tr>
<tr><td>DOCTOR'S SIGNATURE:</td><td>SIGNATURE:<br><br>UC:</td></tr>
</table>