



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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: HNAVFPMB

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, Creatinine** 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, 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, Creatinine Clearance greater than or equal to 60 mL/minute (for CISplatin only)**

Dose modification for: **Hematology** **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

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

dexamethasone 8 mg PO 30 to 60 minutes prior to each treatment

and **select ONE** of the following:

- | | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | aprepitant 125 mg PO 30 to 60 minutes prior to treatment on Day 1, then 80 mg PO daily on Day 2 and 3
ondansetron 8 mg PO 30 to 60 minutes prior to each treatment |
| <input type="checkbox"/> | netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment on Day 1 only |
| <input type="checkbox"/> | ondansetron 8 mg PO 30 to 60 minutes prior to each treatment |

For prior infusion reaction to pembrolizumab:

- 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**

HYDRATION:

Prehydrate with NS 1000 mL over 60 minutes prior to CISplatin

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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DATE:	To be given:	Cycle #:
Have Hypersensitivity Reaction Tray and Protocol Available		
CHEMOTHERAPY:		
<p>pembrolizumab 2 mg/kg x _____ kg = _____ mg (max. 200 mg)</p> <p>IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter (may be given during prehydration)</p>		
<p>CISplatin 75 mg/m² x BSA = _____ mg</p> <p><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg</p> <p>IV in NS 500 mL with potassium chloride 20 mEq, magnesium sulphate 1 g, mannitol 30 g over 1 hour</p> <p>OR</p> <p>CARBOplatin AUC 5 x (GFR + 25) = _____ mg</p> <p><input type="checkbox"/> Dose Modification: _____ % = _____ mg</p> <p>IV in 100 to 250 mL NS over 30 minutes</p>		
<p>fluorouracil 1000 mg/m²/day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96 hours)</p> <p><input type="checkbox"/> Dose Modification: _____ mg/m²/day x BSA = _____ mg/day for 4 days (total dose = _____ mg over 96 h)</p> <p>IV in D5W to a total volume of 480 mL by continuous infusion at 5 mL/h via TWO Baxter LV5 infusors (Total dose should be divided equally – each 240 mL over 48 hours)</p>		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in 2 days for second fluorouracil infusor <input type="checkbox"/> Last Cycle. Return in three weeks for HNAVPMBM (to continue single agent pembrolizumab)		
<p>CBC & Diff, Platelets, Serum Creatinine, ALT, bilirubin, alkaline phosphatase, LDH, sodium, potassium, TSH prior to each 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</p> <p><input type="checkbox"/> Free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol</p> <p><input type="checkbox"/> serum ACTH levels <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH</p> <p><input type="checkbox"/> Glucose</p> <p><input type="checkbox"/> Weekly nursing assessment</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests</p>		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: