



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](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**PROTOCOL CODE: LUAVPPMB**

<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				
May proceed with <b>pemetrexed, CARBOplatin, CISplatin</b> as written if within 96 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L, and Creatinine Clearance greater than or equal to 45mL/minute (for pemetrexed and CARBOplatin), or greater than or equal to 60 mL/minute (for CISplatin)</b>				
May proceed with <b>pembrolizumab</b> as written if within 96 hours creatinine <b>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</b>				
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity:</b> _____ <b>Proceed with treatment based on blood work from</b> _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.				
dexamethasone <input type="checkbox"/> <b>8 mg</b> or <input type="checkbox"/> <b>12 mg</b> (select one) PO 30 to 60 minutes prior to treatment				
AND select <b>ONE</b> of the following:	<input type="checkbox"/>	<b>aprepitant 125 mg</b> PO 30 to 60 minutes prior to treatment, and		
	<input type="checkbox"/>	<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) PO 30 to 60 minutes prior to treatment				
Ensure patient is taking <b>folic acid</b> and has had <b>vitamin B12</b> injection starting at least 7 days prior to first cycle, and to continue while on treatment, until 21 days after last pemetrexed dose.				
For prior infusion reaction: <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>Other:</b> _____				
<b>**Have Hypersensitivity Reaction Tray &amp; Protocol Available**</b>				
<b>HYDRATION:</b>				
1000 mL NS over 1 hour prior to CISplatin				
Continued on page 2				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				<b>UC:</b>



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<b>DATE:</b>	
<b>CHEMOTHERAPY:</b>	
<p><b>pembrolizumab 2 mg/kg x _____ kg = _____ mg (max. 200 mg)</b>          IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter</p> <p><b>pemetrexed 500 mg/m<sup>2</sup> x BSA = _____ mg</b>  <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m<sup>2</sup> x BSA = _____ mg          IV in 100 mL NS over 10 minutes (may be given during prehydration)</p> <p>Select one:</p> <p><input type="checkbox"/> <b>CISplatin 75 mg/m<sup>2</sup> x BSA = _____ mg</b>  <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m<sup>2</sup> x BSA = _____ mg          IV in 500 mL NS, with potassium chloride 20 mEq, magnesium sulphate 1 g and mannitol 30 g over 1 hour</p> <p><b>OR</b></p> <p><input type="checkbox"/> <b>CARBOplatin AUC 5 x (GFR + 25) = _____ mg IV in 100 to 250 mL NS over 30 minutes</b></p>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)	
<p><b>CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH</b> prior to each treatment</p> <p><b>CBC &amp; Diff, Platelets</b> weekly during Cycles 1 and 2</p> <p><b>Vitamin B12 injection</b> required every 9 weeks. Patient to obtain supply.  <input type="checkbox"/> This patient to receive injection in clinic. Next injection due by _____.</p> <p>If clinically indicated: <input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>Chest X-ray</b></p> <p><input type="checkbox"/> <b>serum HCG</b> or <input type="checkbox"/> <b>urine HCG</b> (select one) – required for woman of child bearing potential</p> <p><input type="checkbox"/> <b>Free T3 and free T4</b> <input type="checkbox"/> <b>lipase</b> <input type="checkbox"/> <b>morning serum cortisol</b> <input type="checkbox"/> <b>Glucose</b>  <input type="checkbox"/> <b>serum ACTH levels</b> <input type="checkbox"/> <b>testosterone</b> <input type="checkbox"/> <b>estradiol</b> <input type="checkbox"/> <b>FSH</b> <input type="checkbox"/> <b>LH</b></p> <p><input type="checkbox"/> <b>Weekly nursing assessment</b></p> <p><input type="checkbox"/> <b>Other consults</b></p> <p><input type="checkbox"/> <b>See general orders sheet for additional requests.</b></p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>