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PROTOCOL CODE: GIGAVPCOXT

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REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form DATE: Date of Previous Cycle: To be given: Cycle(s) #:	DOCTOR'S ORDERS	Ht	cm	Wt	kg BSA	m²	
Delay treatment	REMINDER: Please ensure drug allerg	ies and previous bleon	nycin a	are docur	nented on the Allergy	& Alert Form	
Delay treatment		To be given:			Cycle(s) #:		
GBC & Diff day of treatment							
May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10°/L, platelets greater than or equal to 50 mL/minute, creatinine clear 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 1.5 times the upper limit of normal and less than or equal to 1.5 times the upper limit of normal bose modification for: Hematology Other Toxicity							
crequal to 75 x 10 ⁹ /L, creatinine clearance greater than or equal to 55 mL/minute, creatinine less than or equal to 3 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 and less than or equal to 1.5 times the upper limit of normal state to complete the upper limit of normal observation of the upper limit of normal observations of upp	<u> </u>	in 06 hours ANC greater	than	or oqual t	to 1.2 v 109/l inlatelets	areater than	
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, total bilirubin less than or equal to 1.5 times the upper limit of normal Dose modification for:							
Proceed with treatment based on blood work from PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ondansetron 8 mg PO prior to treatment dexamethasone 8 mg or 12 mg (select one) PO prior to treatment NO ice chips For prior pembrolizumab infusion reaction: diphenhydrAMINE 50 mg PO 30 minutes prior to treatment diphenhydrAMINE 50 mg PO 30 minutes prior to treatment diphenhydrAMINE 50 mg PO 30 minutes prior to treatment diphenhydramacist to confirm diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 30 minutes prior to treatment diphenhydramacist 50 mg PO 50 minutes prior to treatment diphenhydramacist 50 mg PO 50 minutes prior to treatment diphenhydramacist 50 mg PO 50 mg Po FNN for trastuzumab bread as prior to treatment diphenhydramacist initial initial substances in trastuzumab brand as per Provincial Systemic Therapy Policy III-190 diphenhydramacist initial and Date diphenhydramacist initial		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					
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ondansetron 8 mg PO prior to treatment dexamethasone	<u>_</u>					mal	
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ondansetron 8 mg PO prior to treatment dexamethasone							
ondansetron 8 mg PO prior to treatment dexamethasone	Proceed with treatment based on blood	d work from					
dexamethasone	PREMEDICATIONS: Patient to take or	wn supply. RN/Pharmac	ist to c	onfirm	· · · · · · · · · · · · · · · · · · ·	·	
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 Other: *** Have Hypersensitivity Reaction Tray & Protocol Available** TREATMENT: pembrolizumab and trastuzumab lines to be primed with NS; oxaliplatin line to be primed with D5W Cycle 1: 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 trastuzumab 8 mg/kg x kg = mg IV in 250 mL NS over 1 hour 30 minutes Observe for 1 hour post infusion Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190 Drug Brand (Pharmacist to complete. Please print.) Pharmacist Initial and Date trastuzumab oxaliplatin 130 mg/m² x BSA = mg IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post dose. To reduce incidence of vascular pain:	ondansetron 8 mg PO prior to treatment						
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DATE:					
☐ Cycle 2:					
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					
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trastuzumab 6 mg/kg x kg = mg IV in 250 mL NS over 7 Observe for 30 minutes post infusion	i nour				
Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Polic	ov III 100				
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trastuzumab					
oxaliplatin 130 mg/m² x BSA = mg					
Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Poli Drug Brand (Pharmacist to complete. Please print.) Ph	narmacist Initial and Date				
trastuzumab					
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To reduce incidence of vascular pain: 250 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 125 mL/h 500 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 250 mL/h					
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acetaminophen 325 to 650 mg PO PRN for trastuzumab-related headache and rigors					
DOCTOR'S SIGNATURE:	SIGNATURE:				
	UC:				



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DATE:				
RETURN APPOINTMENT ORDERS				
Return in three weeks for Doctor and Cycle				
☐ Return in <u>six</u> weeks for Doctor and Cycle & Book chemo x 2 cycles ☐ Last Cycle. Return in week(s)				
CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to each cycle				
If clinically indicated:				
☐ CEA ☐ CA 19-9				
☐ ECG ☐ chest x-ray ☐ MUGA scan or ☐ echocardiogram				
☐ free T3 and free T4 ☐ lipase ☐ morning serum cortisol				
☐ random glucose ☐ alkaline phosphatase ☐ albumin ☐ GGT				
☐ creatine kinase ☐ troponin				
☐ serum ACTH levels ☐ testosterone ☐ estradiol ☐ FSH ☐ LH				
☐ serum HCG or ☐ urine HCG – required for woman of childbearing potential				
☐ INR weekly ☐ INR prior to each cycle				
☐ Weekly nursing assessment				
☐ Other consults:				
☐ See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:	SIGNATURE:			
	UC:			