

PROTOCOL CODE: GIGAVPFOXT

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(s) #:	
Date of Previous Cycle:					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment Day 1: May proceed with doses as written if within 72 hours ANC greater than or equal to 1.2 x 10⁹/L, platelets greater than or equal to 75 x 10⁹/L, 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, creatinine less than or equal to 1.5 times the upper limit of normal and less than or equal to 1.5 x baseline. Days 15 and 29: May proceed with doses as written if within 72 hours ANC greater than or equal to 1.2 x 10⁹/L, platelets greater than or equal to 75 x 10⁹/L. Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ 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 <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO prior to treatment NO ice chips For prior pembrolizumab infusion reaction: <input type="checkbox"/> diphenhydrAMINE 50 mg PO 30 minutes prior to pembrolizumab <input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to pembrolizumab <input type="checkbox"/> hydrocortisone 25 mg IV 30 minutes prior to pembrolizumab <input type="checkbox"/> Other: _____					
** Have Hypersensitivity Reaction Tray & Protocol Available**					
TREATMENT: (Note – continued over 3 pages) pembrolizumab and trastuzumab lines to be primed with NS; oxaliplatin and leucovorin lines to be primed with D5W <input type="checkbox"/> Cycle 1 ONLY: pembrolizumab 4 mg/kg x _____ kg = _____ mg (max. 400 mg) IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter on Day 1 trastuzumab 6 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour 30 minutes on Day 1 Observe for 1 hour post infusion trastuzumab 4 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 1 hour on Day 15 Observe for 30 minutes post infusion trastuzumab 4 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 30 minutes on Day 29 Observe for 30 minutes post infusion Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190					
		** Cycle 1 continued on next page**			
DOCTOR'S SIGNATURE:				SIGNATURE:	
				UC:	

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DATE :

TREATMENT: (Cycle 1, continued):

oxaliplatin 85 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL D5W over 2 hours* on **Days 1, 15, and 29**. Flush line with D5W pre and post dose.

leucovorin 400 mg/m² x BSA = _____ mg IV in 250 mL D5W over 2 hours* on **Days 1, 15, and 29**

*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site

OR

leucovorin 20 mg/m² x BSA = _____ mg

IV push on **Days 1, 15, and 29**

fluorouracil 400 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV push on **Days 1, 15, and 29, THEN**

fluorouracil 2400 mg/m² x BSA = _____ mg**

Dose Modification: _____ mg/m² x BSA = _____ mg**

IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR on **Days 1, 15, and 29**

** For 3000 to 5500 mg dose **select INFUSOR per dose range below (doses outside dose banding range are prepared as ordered):**

Dose Banding Range	Dose Band INFUSOR (mg)	Pharmacist Initial and Date
Less than 3000 mg	Pharmacy to mix specific dose	
3000 to 3400 mg	3200 mg	
3401 to 3800 mg	3600 mg	
3801 to 4200 mg	4000 mg	
4201 to 4600 mg	4400 mg	
4601 to 5000 mg	4800 mg	
5001 to 5500 mg	5250 mg	
Greater than 5500 mg	Pharmacy to mix specific dose	

acetaminophen 325 to 650 mg PO PRN for trastuzumab-related headache and rigors

Cycle 2 onward:

pembrolizumab 4 mg/kg x _____ kg = _____ mg (max. 400 mg)

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter on **Day 1**

trastuzumab 4 mg/kg x _____ kg = _____ mg IV in 250 mL NS over 30 minutes on **Days 1, 15, and 29**

Observation period not required after 3 treatments with no reaction

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		

**** Cycle 2 onward continued on next page****

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TREATMENT: (Cycle 2 onward, continued):

oxaliplatin 85 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL D5W over 2 hours* on **Days 1, 15, and 29**. Flush line with D5W pre and post dose.

leucovorin 400 mg/m² x BSA = _____ mg IV in 250 mL D5W over 2 hours* on Days 1, 15, and 29

*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site

OR

leucovorin 20 mg/m² x BSA = _____ mg

IV push on **Days 1, 15, and 29**

fluorouracil 400 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV push on **Days 1, 15, and 29, THEN**

fluorouracil 2400 mg/m² x BSA = _____ mg**

Dose Modification: _____ mg/m² x BSA = _____ mg**

IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR on **Days 1, 15, and 29**

** For 3000 to 5500 mg dose **select INFUSOR per dose range below (doses outside dose banding range are prepared as ordered):**

Dose Banding Range	Dose Band INFUSOR (mg)	Pharmacist Initial and Date
Less than 3000 mg	Pharmacy to mix specific dose	
3000 to 3400 mg	3200 mg	
3401 to 3800 mg	3600 mg	
3801 to 4200 mg	4000 mg	
4201 to 4600 mg	4400 mg	
4601 to 5000 mg	4800 mg	
5001 to 5500 mg	5250 mg	
Greater than 5500 mg	Pharmacy to mix specific dose	

acetaminophen 325 to 650 mg PO PRN for trastuzumab-related headache and rigors (if not previously given for pembrolizumab reaction)

RETURN APPOINTMENT ORDERS

Return in **six** weeks for Doctor and for Cycle _____. Book chemo on Days 1, 15, and 29

Return in _____ weeks for Doctor assessment

Last Cycle. Return in _____ week(s)

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<p>CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to Day 1 of each cycle</p> <p>CBC & Diff, creatinine, total bilirubin, ALT on Days 15 and 29 of each cycle</p> <p>If clinically indicated:</p> <p><input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9</p> <p><input type="checkbox"/> ECG <input type="checkbox"/> chest x-ray <input type="checkbox"/> MUGA scan or <input type="checkbox"/> echocardiogram</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"/> random glucose <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT</p> <p><input type="checkbox"/> creatine kinase <input type="checkbox"/> troponin</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"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of childbearing potential</p> <p><input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle</p> <p><input type="checkbox"/> Book for PICC assessment / insertion per Centre process</p> <p><input type="checkbox"/> Book for IVAD insertion per Centre process</p> <p><input type="checkbox"/> Weekly nursing assessment</p> <p><input type="checkbox"/> Other consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p>	
DOCTOR'S SIGNATURE:	SIGNATURE:
	UC: