PROTOCOL CODE: UGOEAVDCAT

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

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)
☐ **CBC & Diff** day of treatment

May proceed with PACLitaxel and CARBOplatin as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 100 x 10^9/L**

May proceed with dostarlimab 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, total bilirubin less than or equal to 1.5 times the upper limit of normal**

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

Proceed with treatment based on blood work from _____

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

CYCLES 1 to 6:

☐ No prior infusion reaction to dostarlimab: administer premedications as sequenced below

45 minutes prior to PACLitaxel: **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel: **diphenhydrAMINE 50 mg** IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ Prior infusion reaction to dostarlimab: administer PACLitaxel premedications prior to dostarlimab

45 minutes prior to dostarlimab: **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes

30 minutes prior to dostarlimab: **diphenhydrAMINE 50 mg** IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to dostarlimab

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to CARBOplatin, and **ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to CARBOplatin

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

CYCLE 7 to 23:

For prior dostarlimab 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:**

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DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

PROTOCOL CODE: UGOEAVDCAT

DATE:

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

☐ **Cycle _____ (Cycles 1 to 6):**

dostarlimab 500 mg IV in 100 mL NS over 30 minutes using a 0.2 micron in-line filter* **on Day 1**

PACLitaxel ☐ **175 mg/m²** x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg **on Day 1**
IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use Non DEHP tubing with 0.2 micron in-line filter*)

CARBOplatin AUC ☐ **6** *or* ☐ **5** (*select one*) **x (GFR + 25)** = _____ mg **on Day 1**
☐ Dose Modification: _____% = _____ mg
IV in 100 to 250 mL NS over 30 minutes

* use separate infusion line and filter for each drug

☐ **Cycle _____ (Cycles 7 to 23):**

dostarlimab 1000 mg IV in 100 mL NS over 30 minutes using a 0.2 micron in-line filter **on Day 1** every 6 weeks

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____ (Cycles 1 to 6)
☐ Return in **three** weeks for Doctor and Cycle 7
☐ Return in **six** weeks for Doctor and Cycle _____ (Cycles 8 to 23)
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH prior to each cycle.

If clinically indicated:

☐ **ECG** ☐ **chest x-ray**
☐ **serum HCG or** ☐ **urine HCG** – required for woman of childbearing potential
☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose**
☐ **creatine kinase** ☐ **serum ACTH levels**
☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**
☐ **CA 125** ☐ **CA 15-3** ☐ **CA 19-9**
☐ **Weekly nursing assessment**
☐ **Other consults**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: