PROTOCOL CODE: UGOEAVDPNC

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 NAB 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:

For prior dostarlimab infusion reaction:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to dostarlimab
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to dostarlimab
☐ **hydrocortisone 25 mg** IV 30 minutes prior to dostarlimab

dexamethasone ☐ **8 mg or** ☐ **12 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

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

CYCLES 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:**

Continued on Page 2

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

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 NAB 260 mg/m² x BSA = _____mg on **Day 1**

☐ Dose Modification: _____% = _____mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron 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
☐ **GGT** ☐ **total protein** ☐ **albumin** ☐ **morning serum cortisol** ☐ **lipase**
☐ **random glucose** ☐ **creatine kinase** ☐ **free T3 and free T4** ☐ **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: