PROTOCOL CODE: LUAVATZ

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DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

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:

☐ Delay treatment _____ week(s)
May proceed with doses as written if within 96 hours **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, creatinine **less than or equal to** 1.5 times the upper limit of normal *and* **less than or equal to** 1.5 X baseline.
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
For prior 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

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

TREATMENT: ☐ Repeat in three weeks

☐ **CYCLE 1:**

atezolizumab 1200 mg IV in 250 mL NS over 1 hour*

☐ **CYCLE 2 onwards:**

atezolizumab 1200 mg IV in 250 mL NS over 30 minutes*

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle # _____.
☐ Return in **six** weeks for Doctor and Cycles # _____ and _____. Book chemo x 2 cycles.
☐ Last cycle. Return in _____ week(s).

CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, calcium, TSH prior to each treatment
If clinically indicated: ☐ **ECG** ☐ **Chest X-ray**
☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential
☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol**
☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **Glucose**
☐ **Weekly nursing assessment**
☐ **Other consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: