BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAVSG

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 doses as written on **Day 1** if within 72 hours **ANC <u>greater than or equal to</u> 1.5 x 10^9/L, platelets <u>greater than or equal to</u> 75 x 10^9/L**

May proceed with doses as written on **Day 8** if within 24 hours **ANC <u>greater than or equal to</u> 1.0 x 10^9/L, platelets <u>greater than or equal to</u> 75 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** ______________________________
Proceed with treatment based on blood work from ______________________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ________________________.
dexamethasone ☐ **8 mg or** ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment

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

If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment

<u>30 Minutes Prior to treatment</u>:

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

For prior cholinergic response:
☐ **Prophylactic atropine 0.3** mg subcutaneously 30 minutes prior to treatment

For prior infusion reaction:
☐ **hydrocortisone 100 mg** IV 30 minutes prior to treatment
☐ **Other:**

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

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE # 1 Day 1**
sacituzumab govitecan 10 mg/kg x _______ kg = ________ mg
☐ Dose Modification: ________% = ________ mg/kg = ________ mg
IV in 100 to 1000 mL NS over 3 hours on **Day 1**. Observe for 30 minutes post-infusion

☐ **CYCLE # 1 Day 8**
sacituzumab govitecan 10 mg/kg x _______ kg = ________ mg
☐ Dose Modification: ________% = ________ mg/kg = ________ mg
IV in 100 to 1000 mL NS over 1 hour on **Day 8**. Observe for 30 minutes post-infusion.

**** SEE PAGE 2 FOR CYCLE 2 ONWARDS ****

DOCTOR SIGNATURE:	**SIGNATURE:** **UC:**

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DOCTOR'S ORDERS Ht__________cm Wt__________kg BSA__________m^2

DATE: **To be given:** **Cycle #:**

Have Hypersensitivity Reaction Tray and Protocol Available

CHEMOTHERAPY (Continued):

OR

☐ **CYCLE # 2 onwards**

sacituzumab govitecan 10 mg/kg x _______ kg = ________ mg

☐ Dose Modification: ________% = ________ mg/kg = ________ mg

IV in 100 to 1000 mL NS over 1 hour on **Days 1 and 8**. Observe for 30 minutes post-infusion.

Counsel patient to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO with each episode of diarrhea until diarrhea free x 12 hours.

atropine 0.3 mg subcutaneously prn. May repeat every 30 min to a **maximum dose of 1.2 mg** for diarrhea, abdominal cramps, rhinorrhea, increased salivation, lacrimation, diaphoresis or flushing.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle______. Book chemo Day 1 and Day 8.

☐ Last Cycle. Return in ________ weeks.

CBC & Diff prior to each treatment (for Day 1 and Day 8)

If clinically indicated:

☐ **Total Bilirubin** ☐ **Direct Bilirubin** ☐ **Alk Phos** ☐ **ALT** ☐ **LDH** ☐ **Albumin**

☐ **Total Protein** ☐ **Glucose** ☐ **Creatinine** ☐ **BUN** ☐ **Sodium** ☐ **Potassium**

☐ **Calcium** ☐ **Magnesium** ☐ **Phosphorous** ☐ **CA 15-3**

☐ **ECG**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR SIGNATURE:

SIGNATURE:

UC: