PROTOCOL CODE: GIAVPEMPG

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 pembrolizumab as written if within 48 hours **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 times baseline.

May proceed with gemcitabine and CISplatin or CARBOplatin doses as written if within 48 hours **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 100 x 10^9/L, creatinine clearance greater than or equal to 60 mL/min (if using CISplatin)**

Dose modification for: ☐ Hematology ☐ Other Toxicity: _____

Proceed with treatment based on blood work from _____

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

Cycles 1 to 8:

☐ CISplatin option:

dexamethasone ☐ **8 mg** or ☐ **12 mg** *(select one)* PO 30 minutes prior to CISplatin on Days 1 and 8
ondansetron 8 mg PO 30 minutes prior to CISplatin on Days 1 and 8

☐ CARBOplatin option:

dexamethasone ☐ **8 mg** or ☐ **12 mg** *(select one)* PO 30 minutes prior to CARBOplatin on Day 1

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

If additional antiemetic required:

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

For prior pembrolizumab infusion reaction:

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

Cycle 9 onward:

☐ **prochlorperazine 10 mg** PO or ☐ **metoclopramide 10 mg** PO 30 minutes prior to gemcitabine on Days 1 and 8

For prior pembrolizumab infusion reaction:

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

☐ **Other:**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:

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

TREATMENT

☐ **CYCLE _____ (Cycles 1 to 8):**

pembrolizumab 2 mg/kg x _____ kg = _____mg **(max. 200 mg)** on **Day 1**

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

gemcitabine 1000 mg/m^2/day x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2/day x BSA = _____ mg

IV in 250 mL NS over 30 minutes on **Days 1 and 8**

CISplatin 25 mg/m^2/day x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2/day x BSA = _____ mg

IV in 100 to 250 mL NS IV over 30 minutes on **Days 1 and 8**

OR

CARBOplatin AUC 5 x (GFR + 25) = _____mg IV in 100 to 250 mL NS over 30 minutes on **Day 1**

DOSE MODIFICATION IF REQUIRED ON DAY 8 (Cycles 1 to 8):

gemcitabine 1000 mg/m^2/day x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2/day x BSA = _____ mg

IV in 250 mL NS over 30 minutes on **Day 8**

CISplatin 25 mg/m^2/day x BSA = _____ mg **(not applicable if CARBOplatin Day 1)**

☐ Dose Modification: _____% = _____ mg/m^2/day x BSA = _____ mg

IV in 100 to 250 mL NS IV over 30 minutes on **Day 8**

See page 3 for Treatment Cycle 9 onward

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:

TREATMENT (3-weekly option or 6-weekly option)

☐ **CYCLE _____ (Cycle 9 onward)**

3 weekly-option

pembrolizumab 2 mg/kg x _____ kg = _____mg **(max. 200 mg)** on **Day 1 every 3 weeks**
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

gemcitabine 1000 mg/m^2/day x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2/day x BSA = _____ mg
IV in 250 mL NS over 30 minutes on **Days 1 and 8 every 3 weeks**

DOSE MODIFICATION IF REQUIRED ON DAY 8:

gemcitabine 1000 mg/m^2/day x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2/day x BSA = _____ mg
IV in 250 mL NS over 30 minutes on **Day 8**

☐ **CYCLE _____ (Cycle 9 onward):**

6 weekly-option

pembrolizumab 4 mg/kg x _____ kg = _____mg **(max. 400 mg)** on **Day 1** every 6 weeks
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____. Book treatment Day 1 & 8 (Cycles 1 to 8) ☐ Return in **three** weeks for Doctor and Cycle _____. Book treatment Days 1 & 8 (Cycle 9 onward, gemcitabine and pembrolizumab given) ☐ Return in **six** weeks for Doctor and Cycle _____. Book treatment Day 1 only. (Cycle 9 onward, pembrolizumab monotherapy) ☐ Last cycle. Return in _____ week(s).	
CYCLES 1 to 8: **CBC & Diff, creatinine, ALT, total bilirubin sodium, potassium, TSH** prior to Day 1 **CBC & Diff** prior to Day 8 **creatinine** prior to Day 8 (required if using CISplatin) **CYCLE 9 onward:** **CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH** prior to Day 1 ☐ **CBC & Diff** prior to Day 8 (required if gemcitabine is given) If clinically indicated: ☐ **CEA** ☐ **CA19-9** ☐ **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** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **creatine kinase** ☐ **troponin** ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **weekly nursing assessment** ☐ **Other tests:** ☐ **Other consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**