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)

☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, creatinine clearance greater than or equal to 50 mL/minute, 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. RN/Pharmacist to confirm _____.

ondansetron 8 mg PO prior to treatment

dexamethasone ☐ **8 mg** or ☐ **12 mg** *(select one)* PO prior to treatment (omit if below dexamethasone IV premedication ordered)

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

☐ For prior oxaliplatin hypersensitivity reactions (Grade 1 or 2):
45 minutes prior to oxaliplatin: **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes
30 minutes prior to oxaliplatin: **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)

For patients with prior pembrolizumab and oxaliplatin reaction, administer oxaliplatin premedications prior to pembrolizumab

NO ice chips

☐ **Other:**

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

DATE:

**** Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT:

pembrolizumab and trastuzumab lines to be primed with NS; oxaliplatin line to be primed with D5W

☐ **Cycle 1:**

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

trastuzumab 8 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour 30 minutes
Observe for 1 hour post infusion
Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

oxaliplatin 130 mg/m² x BSA = _____ mg
☐ Dose Modification: _____mg/m² x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post dose.

For moderate vascular pain during peripheral administration:
250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn
OR ☐ 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn

capecitabine 1000 mg/m² or _____ x BSA x (_____%) = _____ mg PO BID x 14 days on **Days 1 to 14**
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

acetaminophen 325 to **650 mg** PO PRN for trastuzumab-related headache and rigors

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

DATE:

**** Have Hypersensitivity Reaction Tray & Protocol Available****

☐ **Cycle 2:**

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

trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour
Observe for 30 minutes post infusion
Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

oxaliplatin 130 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post dose.

For moderate vascular pain during peripheral administration:
250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn
OR ☐ 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn

capecitabine 1000 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO BID x 14 days on **Days 1 to 14**
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

☐ **Cycle 3 and Subsequent:** ☐ **Repeat in three weeks**

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

trastuzumab 6 mg/kg x ____ kg =_____mg IV in 250 mL NS over 30 minutes
Observe for 30 minutes post infusion. Observation period not required after 3 treatments with no reaction
Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

oxaliplatin 130 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post dose.

For moderate vascular pain during peripheral administration:
250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn
OR ☐ 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn

capecitabine 1000 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO BID x 14 days on **Days 1 to 14**
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

acetaminophen 325 to **650 mg** PO PRN for trastuzumab-related headache and rigors

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

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____ ☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book treatment x 2 cycles ☐ Last Cycle. Return in _____ week(s)	
CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to each cycle If clinically indicated: ☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **chest x-ray** ☐ **MUGA scan** or ☐ **echocardiogram** ☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **creatine kinase** ☐ **troponin** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **serum HCG or** ☐ **urine HCG** – required for woman of childbearing potential ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **Weekly nursing assessment** ☐ **Other consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**