PROTOCOL CODE: GIGAVPFOXT

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(s) #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

Day 1: May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.2 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, 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 x baseline**.

Days 15 and 29: May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.2 x 10^9/L**, **platelets greater than or equal to 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 _____.
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:**

TREATMENT: (Note – continued over 3 pages)

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

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

**** Cycle 1 continued on next page****

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

DATE:

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

TREATMENT: (Cycle 1, continued):

trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour 30 minutes on **Day 1**
Observe for 1 hour post infusion

trastuzumab 4 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour on **Day 15**
Observe for 30 minutes post infusion

trastuzumab 4 mg/kg x ____ kg =_____mg IV in 250 mL NS over 30 minutes on **Day 29**
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 85 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours* on **Days 1, 15, and 29.** Flush line with D5W pre and post dose.

leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted)

☐ **leucovorin 400 mg/m^2** x BSA = _____ mg IV in 250 mL D5W over 2 hours* on **Days 1, 15, and 29**
*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site

OR

☐ **leucovorin 20 mg/m^2** x BSA = _____ mg IV push on **Days 1, 15, and 29**

flourouracil IV push (optional)

☐ **fluorouracil 400 mg/m^2** x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV push on **Days 1, 15, and 29, THEN**

fluorouracil infusion (required)

fluorouracil 2400 mg/m^2 x BSA = _____ mg**
☐ Dose Modification: _____mg/m^2 x BSA = _____mg**
IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR on **Days 1, 15, and 29**

** For 3000 to 5500 mg dose **select INFUSOR per dose range below (doses outside** dose banding range are **prepared as ordered):**

Dose Banding Range	Dose Band INFUSOR (mg)	Pharmacist Initial and Date
Less than 3000 mg	Pharmacy to mix specific dose	
3000 to 3400 mg	3200 mg	
3401 to 3800 mg	3600 mg	
3801 to 4200 mg	4000 mg	
4201 to 4600 mg	4400 mg	
4601 to 5000 mg	4800 mg	
5001 to 5500 mg	5250 mg	
Greater than 5500 mg	Pharmacy to mix specific dose	

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****

TREATMENT (Continued):

☐ **Cycle 2 onward:**

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

trastuzumab 4 mg/kg x ____ kg =_____mg IV in 250 mL NS over 30 minutes on **Days 1, 15, and 29**
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 85 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours***** on **Days 1, 15, and 29.** Flush line with D5W pre and post dose.

leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted)

☐ **leucovorin 400 mg/m^2** x BSA = _____ mg IV in 250 mL D5W over 2 hours* on **Days 1, 15, and 29**
*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site

OR

☐ **leucovorin 20 mg/m^2** x BSA = _____ mg IV push on **Days 1, 15, and 29**

flourouracil IV push (optional)

fluorouracil 400 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV push on **Days 1, 15, and 29, THEN**

fluorouracil Infusion (required)

fluorouracil 2400 mg/m^2 x BSA = _____ mg**
☐ Dose Modification: _____mg/m^2 x BSA = _____mg**
IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR on **Days 1, 15, and 29**
** For 3000 to 5500 mg dose **select INFUSOR per dose range below (doses outside** dose banding range are **prepared as ordered):**

Dose Banding Range	Dose Band INFUSOR (mg)	Pharmacist Initial and Date
Less than 3000 mg	Pharmacy to mix specific dose	
3000 to 3400 mg	3200 mg	
3401 to 3800 mg	3600 mg	
3801 to 4200 mg	4000 mg	
4201 to 4600 mg	4400 mg	
4601 to 5000 mg	4800 mg	
5001 to 5500 mg	5250 mg	
Greater than 5500 mg	Pharmacy to mix specific dose	

acetaminophen 325 to **650 mg** PO PRN for trastuzumab-related headache and rigors (if not previously given for pembrolizumab reaction)

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **six** weeks for Doctor and for Cycle _____. Book treatment on Days 1, 15, and 29 ☐ Return in _____ weeks for Doctor assessment ☐ Last Cycle. Return in _____ week(s)	
CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to Day 1 of each cycle **CBC & Diff, creatinine, total bilirubin, ALT** on Days 15 and 29 of 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 ☐ **Book for PICC assessment / insertion per Centre process** ☐ **Book for IVAD insertion per Centre process** ☐ **Weekly nursing assessment** ☐ **Other consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**