PROTOCOL CODE: UGOCXCATBP

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

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**, **Platelets on** day of treatment

May proceed with doses as written if within 96 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 **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, bilirubin less than or equal to 1.5 times the upper limit of normal, BP less than or equal to 150/100,** and **urine dipstick for protein negative or 1+.**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

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

☐ No prior infusion reaction to pembrolizumab: administer premedications as sequenced below

45 minutes prior to PACLitaxel:

dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel:

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)

☐ Prior infusion reaction to pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab

45 minutes prior to pembrolizumab:

dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to pembrolizumab:

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 30 minutes prior to pembrolizumab

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

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

☐ **Other:**

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DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

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

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

TREATMENT:

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*

PACLitaxel ☐ **175 mg/m²** x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter*)

CARBOplatin AUC 5 x (GFR + 25) x = _____ mg

☐ Dose Modification: _____% = _____ mg
IV in 100 to 250 mL NS over 30 minutes.

Blood pressure measurement pre-bevacizumab dose.

bevacizumab ☐ **15 mg/kg** *or* ☐ _____ mg/kg (*select one*) x _____ kg = _____ mg
IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour).
(Blood pressure measurement post-bevacizumab infusion for first 3 cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

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

* use separate infusion line and filter for each drug

DOCTOR'S SIGNATURE:	SIGNATURE: UC:

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DATE:	**Page 3 of 3**	
RETURN APPOINTMENT ORDERS		
Return in **three** weeks for Doctor and Cycle _____ ☐ Last Cycle. Return in three weeks for GOCXPB or GOCXPB6 (to continue pembrolizumab with or without bevacizumab)		
CBC & Diff, Platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle. ☐ **24 hr urine for total protein** within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein ☐ **INR** weekly ☐ **INR** prior to next cycle 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** ☐ **Glucose** ☐ **GGT** ☐ **total protein** ☐ **albumin** ☐ **creatine kinase** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **Weekly nursing assessment** ☐ **Other consults** ☐ **See general orders sheet for additional requests.**		
DOCTOR'S SIGNATURE:		**SIGNATURE:** **UC:**