

PROTOCOL CODE: UGOCXCATP

Page 1 of 2

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:			
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment			
May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/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			
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____			
Proceed with treatment based on blood work from _____			
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.			
<input type="checkbox"/> No prior infusion reaction to pembrolizumab: administer premedications as sequenced below			
<u>45 minutes prior to PACLitaxel:</u> dexamethasone 20 mg IV in 50 mL NS over 15 minutes			
<u>30 minutes prior to PACLitaxel:</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)			
<input type="checkbox"/> Prior infusion reaction to pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab			
<u>45 minutes prior to pembrolizumab:</u> dexamethasone 20 mg IV in 50 mL NS over 15 minutes			
<u>30 minutes prior to pembrolizumab:</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)			
<input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to pembrolizumab			
AND select ONE of the following:	<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin	
	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin	
	<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin	
If additional antiemetic required:			
<input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin			
<input type="checkbox"/> Other:			
Continued on Page 2			
DOCTOR'S SIGNATURE:			SIGNATURE:
			UC:

PROTOCOL CODE: UGOCXCATP

Page 2 of 2

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

DOCTOR'S ORDERS		Page 2 of 2
DATE:	To be given:	Cycle #:
Have Hypersensitivity Reaction Tray and Protocol Available		
TREATMENT:		
<p>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*</p>		
<p>PACLitaxel <input type="checkbox"/> 175 mg/m² x BSA = _____ mg <input type="checkbox"/> 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*)</p>		
<p>CARBOplatin AUC 5 x (GFR + 25) x = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 30 minutes</p>		
* use separate infusion line and filter for each drug		
RETURN APPOINTMENT ORDERS		
Return in <input type="checkbox"/> three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in three weeks for GOCXPB or GOCXPB6 (to continue pembrolizumab)		
<p>CBC & Diff, Platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH prior to each cycle.</p> If clinically indicated: <input type="checkbox"/> ECG <input type="checkbox"/> Chest X-ray <p><input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of child bearing potential <input type="checkbox"/> Free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> Glucose <input type="checkbox"/> GGT <input type="checkbox"/> total protein <input type="checkbox"/> albumin <input type="checkbox"/> creatine kinase <input type="checkbox"/> serum ACTH levels <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> Weekly nursing assessment <input type="checkbox"/> Other consults <input type="checkbox"/> See general orders sheet for additional requests.</p>		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: