

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: HNAVPCPMB

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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 g	iven:			Cycle #	:	
Date of Previous Cycle:						
☐ Delay treatment week(s)						
☐ 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 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 1.5 times the upper limit of normal, bilirubin less than or equal to 1.5 times the upper limit of normal						
Dose modification for: Hematology Proceed with treatment based on blood work f	rom			: _		
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 ov (Y-site compatible)	er 15 minutes ar	nd fam o	otidine 20	mg IV in	NS 100 m	L over 15 minutes
ondansetron 8 mg PO prior to CARBOplatin						
☐ 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						
ondansetron 8 mg PO prior to CARBOplatin						
Continued on page 2						
DOCTOR'S SIGNATURE:				SIC	SNATUR	RE:
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DATE:					
Have Hypersensitivity Reaction Tray & Protocol Available					
CHEMOTHERAPY:					
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 (use non-DEHP bag) NS over 3 hours (use non-DEHP tubing with	n 0.2 micron in-line filter*)				
CARBOplatin AUC 5 or 6 (select one) x (GFR + 25) = mg					
☐ Dose Modification:% = mg IV in 100 to 250 mL NS over 30 minutes					
* use separate infusion line and filter for each drug					
RETURN APPOINTMENT ORDERS					
Return in three weeks for Doctor and Cycle Last Cycle. Return in week(s)					
CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH prior to each treatment					
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					
☐ serum ACTH levels ☐ testosterone ☐ estradiol ☐ FSH ☐ LH					
□ Weekly nursing assessment					
☐ Other consults					
☐ See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:	SIGNATURE:				
	UC:				