**PROTOCOL CODE: HNAVPCPMB**



# 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 #:**

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 1.0 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**

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:**

**Continued on page 2**

| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |
|---|---|

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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/m$^2$** x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m$^2$ x BSA = _____ mg

IV in 250 to 500 mL (use non-DEHP bag) NS over 3 hours (use non-DEHP tubing with 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 & Diff, 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:**