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: UHNAVPFPMB

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

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, Platelets, Creatinine** day of treatment

May proceed with doses as written if within 96 hours **ANC <u>greater than or equal to</u> 1.0 x 10^9/L, Platelets <u>greater than or equal to</u> 100 x 10^9/L, ALT <u>less than or equal to</u> 3 times the upper limit of normal, <u>bilirubin less than or equal to</u> 1.5 times the upper limit of normal,** creatinine **<u>less than or equal to</u>** 1.5 times the upper limit of normal *and* **<u>less than or equal to</u>** 1.5 times the baseline, **Creatinine Clearance <u>greater than or equal to</u> 60 mL/minute (for CISplatin only)**

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

Proceed with treatment based on blood work from ____

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

dexamethasone 8 mg PO 30 to 60 minutes prior to each treatment

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1, then **80 mg** PO daily on Day 2 and 3 **ondansetron 8 mg** PO 30 to 60 minutes prior to each treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment on Day 1 only
☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to each treatment

For prior infusion reaction to pembrolizumab:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to treatment

☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to treatment

☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment

HYDRATION:

Prehydrate with NS 1000 mL over 60 minutes prior to CISplatin

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

Provincial Health Services Authority

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: UHNAVPFPMB

DATE:	To be given:	Cycle #:

****Have Hypersensitivity Reaction Tray and 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 (may be given during prehydration)

CISplatin 75 mg/m² x BSA = ___________mg

☐ Dose Modification: ________% = ___________mg/m² x BSA = _________mg

IV in NS 500 mL with potassium chloride 20 mEq, magnesium sulphate 1 g, mannitol 30 g over 1 hour

OR

CARBOplatin AUC 5 x (GFR + 25) = _________mg

☐ Dose Modification: ________% = _________mg

IV in 100 to 250 mL NS over 30 minutes

fluorouracil 1000 mg/m²/day x BSA = _________mg/day for 4 days (total dose = ____________mg over 96 hours)

☐ Dose Modification: ________mg/m² x BSA = _______mg/day for 4 days (total dose = ___________mg over 96 h)

IV in D5W to a total volume of 480 mL by continuous infusion at 5 mL/h via TWO Baxter LV5 infusors (Total dose should be divided equally – each 240 mL over 48 hours)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _________

☐ Return in 2 days for second fluorouracil infusor

☐ Last Cycle. Return in **three** weeks for HNAVPMBM (to continue single agent pembrolizumab)

CBC & Diff, Platelets, Serum Creatinine, ALT, bilirubin, alkaline phosphatase, LDH, sodium, potassium, TSH prior to each 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**

☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**

☐ **Glucose**

☐ **Weekly nursing assessment**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests**

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