PROTOCOL CODE: LUAVPGPMB

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 24 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 Clearance greater than or equal to 60 mL/minute (if using CISplatin),** 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 _____.

dexamethasone 8 mg or **12 mg** (circle one) PO 30 to 60 minutes prior to treatment on Day 1

AND select **ONE** of the following:	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1, and **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment on Day 1
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment on Day 1
	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment on Day 1

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment on Day 1

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

☐ Other:

****Have Hypersensitivity Reaction Tray & Protocol Available****

HYDRATION:

1000 mL NS over 1 hour prior to CISplatin

Continued on page 2

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:

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 **Day 1**

gemcitabine 1000 mg/m² x BSA = _____ mg
☐ Dose Modification: (_____%) = _____mg/m² x BSA = _____mg
IV in 250 mL NS over 30 minutes on **Day 1 and Day 8**

CISplatin 75 mg/m²/day x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 500 mL NS, with potassium chloride 20 mEq, magnesium sulfate 1 g and mannitol 30 g over 1 hour **Day 1**

OR

CARBOplatin AUC 5 x (GFR + 25) = _____ mg IV in 100 to 250 mL NS over 30 minutes **Day 1**

DOSE MODIFICATION FOR DAY 8

gemcitabine 1000 mg/m² x BSA = _____ mg
☐ Dose Modification: (_____%) = _____mg/m² x BSA = _____mg
IV in 250 mL NS over 30 minutes

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____. Book chemo Day 1 and 8.
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH prior to each treatment

CBC & Diff, creatinine prior to Day 8

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: