PROTOCOL CODE: LUAVPPOSI

(Cycles 1 to 4)

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 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L,** and **creatinine clearance greater than or equal to 45mL/minute (**for pemetrexed and CARBOplatin**),** or **greater than or equal to 60 mL/minute** (for CISplatin)

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** (select one) PO 30 to 60 minutes prior to treatment

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

If additional antiemetic required:

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

Ensure patient is taking **folic acid** and has had **vitamin B12** injection starting at least 7 days prior to first cycle, and to continue while on treatment, until 21 days after last pemetrexed dose.

☐ **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:

PROTOCOL CODE: LUAVPPOSI

(Cycles 1 to 4)

DATE:

TREATMENT:

pemetrexed 500 mg/m² x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 100 mL NS over 10 minutes (may be given during prehydration)

Select one:

☐ **CISplatin 75 mg/m²** x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 500 mL NS, with potassium chloride 20 mEq, magnesium sulphate 1 g and 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

osimertinib 80 mg PO once daily

☐ Dose modification: **osimertinib 40 mg** PO once daily

Supply for: _____ days (maximum 90 days)

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, calcium, magnesium prior to each treatment

Vitamin B12 injection required every 9 weeks. Patient to obtain supply.

☐ This patient to receive injection in clinic. Next injection due by _____.

If clinically indicated: ☐ **ECG** ☐ **Chest X-ray** ☐ **CT scan (chest)**

☐ **MUGA scan** or ☐ **echocardiogram** (select one)

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: