PROTOCOL CODE: SMMCCAVE

DOCTOR'S ORDERS

Wt_____kg

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)

May proceed with doses as written if within 96 hours **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,** creatinine **less than or equal to** 1.5 times the upper limit of normal *and* **less than or equal to** 1.5 X baseline.

Proceed with treatment based on blood work from _____

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

For first 4 cycles: **30 minutes prior to treatment**

diphenhydrAMINE 50 mg IV in 50 mL NS over 20 min and **acetaminophen 500 mg to 650 mg** PO

Then as indicated based on previous reaction:

☐ **diphenhydrAMINE 50 mg** IV in 50 mL NS over 20 min (30 minutes prior to avelumab)

☐ **acetaminophen 500 mg to 650 mg** PO 30 minutes prior to avelumab

☐ **other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT: ☐ Repeat in two weeks

avelumab 10 mg/kg x _____kg = _____ mg

IV in 250 mL NS over 1 hour using a 0.2 micron in-line filter

RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and Cycle _____

☐ Return in **four** weeks for Doctor and Cycles _____ and _____. Book for 2 cycles.

☐ Last cycle. Return in _____ **week(s)**

CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, random glucose prior to each treatment

If clinically indicated: ☐ **ECG** ☐ **Chest X-ray** ☐ **CT scan**_____

☐ **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 (fasting)**

☐ **Weekly nursing assessment**

☐ **Other consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: