



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

**PROTOCOL CODE: GOCXBP6**

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>						
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form								
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>						
Date of Previous Cycle:								
<input type="checkbox"/> Delay treatment _____ week(s) May proceed with doses as written if within 96 hours creatinine <b>less than or equal to</b> 1.5 times the upper limit of normal <b>and less than or equal to</b> 1.5 times the baseline, <b>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</b> , and, if using bevacizumab, if within 96 hours <b>BP less than or equal to 150/100</b> , and <b>Day 1 and Day 22 urine dipstick for protein negative or 1+</b>								
Dose modification for: <input type="checkbox"/> <b>Hematology</b> _____ <input type="checkbox"/> <b>Toxicity</b> _____								
<b>PREMEDICATIONS:</b> Not usually required. If ordered, patient to take own supply. RN/Pharmacist to confirm _____  For prior pembrolizumab infusion reaction: <input type="checkbox"/> <b>diphenhydrAMINE 50 mg</b> PO 30 minutes prior to treatment <input type="checkbox"/> <b>acetaminophen 325 to 975 mg</b> PO 30 minutes prior to treatment <input type="checkbox"/> <b>hydrocortisone 25 mg</b> IV 30 minutes prior to treatment								
<b>TREATMENT:</b>  <b>pembrolizumab 4 mg/kg</b> x _____ kg = _____ mg ( <b>max. 400 mg</b> ) on <b>Day 1 only</b> IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter  If using bevacizumab: <input type="checkbox"/> <b>bevacizumab 15 mg/kg</b> x _____ kg = _____ mg IV in 100 to 250 mL NS over 30 minutes on <b>Days 1 and 22.</b>  (Blood pressure measurement prior to bevacizumab) Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190								
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="padding: 5px;">Drug</th> <th style="padding: 5px;">Brand (Pharmacist to complete. Please print.)</th> <th style="padding: 5px;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">bevacizumab</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> </tbody> </table>	Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date	bevacizumab				
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<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>						
		<b>UC:</b>						



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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
Return in <b>six</b> weeks for Doctor and Cycle _____. Book chemo on Days 1 and 22.	
<input type="checkbox"/> <b>Last cycle.</b> Return in _____ weeks.	
<p><b>CBC and differential, platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH</b> prior to each cycle</p> <p>If patient on bevacizumab:  <b>Dipstick Urine or laboratory urinalysis for protein</b> prior to each bevacizumab treatment</p> <p><input type="checkbox"/> <b>24-hour urine for total protein</b> within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein</p> <p><input type="checkbox"/> <b>INR</b> weekly    <input type="checkbox"/> <b>INR</b> prior to next cycle</p> <p>If clinically indicated: <input type="checkbox"/> <b>ECG</b>    <input type="checkbox"/> <b>Chest X-ray</b></p> <p><input type="checkbox"/> <b>serum HCG</b> or <input type="checkbox"/> <b>urine HCG</b> – required for woman of child bearing potential  <input type="checkbox"/> <b>Free T3 and free T4</b>    <input type="checkbox"/> <b>lipase</b>    <input type="checkbox"/> <b>morning serum cortisol</b>  <input type="checkbox"/> <b>Glucose</b>    <input type="checkbox"/> <b>GGT</b>    <input type="checkbox"/> <b>total protein</b>    <input type="checkbox"/> <b>albumin</b>    <input type="checkbox"/> <b>creatine kinase</b>  <input type="checkbox"/> <b>serum ACTH levels</b>    <input type="checkbox"/> <b>testosterone</b>    <input type="checkbox"/> <b>estradiol</b>    <input type="checkbox"/> <b>FSH</b>    <input type="checkbox"/> <b>LH</b>  <input type="checkbox"/> <b>Weekly nursing assessment</b>  <input type="checkbox"/> <b>Other consults</b>  <input type="checkbox"/> <b>See general orders sheet for additional requests.</b></p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>