BC CANCER
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 and according to acceptable standards of care

PROTOCOL CODE: BRPCTAC

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

On Day 1: may proceed with doses as written if within 48 h: **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 90 x 10^9/L, ALT less than or equal to 3 times the upper limit of normal, total 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 times the baseline.**

On Days 8 and 15: may proceed with doses as written if within 24 h: **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 90 x 10^9/L**

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

Proceed with treatment based on blood work from __________________________________

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

CYCLE # 1 to 8 (pembrolizumab premedications)

For prior pembrolizumab infusion reaction (and receiving PACLitaxel premedications):

- ☐ Give PACLitaxel premedications prior to pembrolizumab infusion

For prior pembrolizumab infusion reaction (if **not** receiving PACLitaxel premedications):

- ☐ **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

☐ **CYCLE # 1 to 4**

45 Minutes Prior to PACLitaxel:
dexamethasone 10 mg IV in NS 50 mL over 15 minutes

30 Minutes Prior to PACLitaxel:
diphenhydrAMINE 25 mg IV in 50 mL NS over 15 minutes and **famotidine 20 mg** IV in 100 mL NS over 15 minutes (Y-site compatible)

☐ No premedication to PACLitaxel required (see protocol for guidelines)

If not receiving IV dexamethasone for PACLitaxel, give: **dexamethasone** ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

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

☐ **CYCLE # 5 to 8**

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment

AND select ONE of the following:		
	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**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

CYCLE #1 to 8 - If additional antiemetic required:

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

***** SEE PAGE 2 FOR TREATMENT ORDERS *****

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

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DATE:

****Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4****

TREATMENT:

☐ **CYCLE #_________ (Cycles 1 to 4)**

pembrolizumab 2 mg/kg x ______ kg = _________ mg **(maximum 200 mg)**

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter* **Day 1 only**

Pharmacist to select **dose band** per last page of PPO. Complete table below (please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

PACLitaxel ☐ **80 mg/m²** OR ☐ ________ **mg/m²** (select one) x BSA = __________ mg

☐ Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg

IV in 100 to 500 mL (non-DEHP bag) NS over 60 minutes on **Days 1, 8 and 15** (use non-DEHP tubing with 0.2 micron in-line filter*)

CARBOplatin AUC ☐ **5 or** ☐ **4** (select one) **x (GFR + 25)** = __________ mg

☐ Dose Modification: ________ % = ________ mg

IV in 100 to 250 mL NS over 30 minutes on **Day 1 only**

* Use separate infusion line and filter for each drug

OR

☐ **CYCLE #_________ (Cycles 5 to 8)**

pembrolizumab 2 mg/kg x ______ kg = _________ mg **(maximum 200 mg)**

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

Pharmacist to select **dose band** per last page of PPO. Complete table below (please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

DOXOrubicin 60 mg/m² x BSA = __________mg

☐ Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg

IV push

cyclophosphamide 600 mg/m² x BSA =__________mg

☐ Dose Modification: ________% = ________ mg/m² x BSA = ___________ mg

IV in 100 to 250 mL NS over 20 to 60 minutes

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DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle ___________ (Book treatment weekly x 3 for Cycles 1-4; book treatment every three weeks for Cycles 5-8, Cycle 5 to start week 13) ☐ Book filgrastim (G-CSF) subcutaneous teaching and first dose on Cycle ____ Day ____ ☐ Last Cycle. Return in **three** weeks for BRAJPEM (to continue single agent pembrolizumab) ☐ Last Cycle. Return in _______ week(s).	
Cycles 1 to 4: **CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, creatine kinase** prior to each cycle. **CBC & Diff** prior to treatment on Days 8 and 15. Cycles 5 to 8: **CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, creatine kinase sodium, potassium, TSH** prior to each cycle. If clinically indicated: ☐ **ECG** ☐ **chest x-ray** ☐ **serum HCG or** ☐ **urine HCG** – required for woman of childbearing potential ☐ **GGT** ☐ **FSH** ☐ **LH** ☐ **random glucose** ☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **troponin** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **Weekly nursing assessment for (specify concern): ____________________** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PEMBROLIZUMAB DOSE BANDING TABLE (2 mg/kg capped 200 mg)

Ordered Dose (mg)		**Rounded dose (mg)**
From:	**To:**	
Less than 70		**Pharmacy prepares specific dose**
70	80.49	**75**
80.5	92.49	**85**
92.5	110.49	**100**
110.5	137.49	**125**
137.5	162.49	**150**
162.5	187.49	**175**
187.5	200	**200**