

**PROTOCOL CODE: GOEAVDCAT**

Page 1 of 2

**DOCTOR'S ORDERS**

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

**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 PACLitaxel and CARBOplatin as written if within 96 hours **ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 100 x 10<sup>9</sup>/L**

May proceed with dostarlimab as written if within 96 hours 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, **total 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 of oral medications. RN/Pharmacist to confirm \_\_\_\_\_.

**CYCLES 1 to 6:**

- No prior infusion reaction to dostarlimab: administer premedications as sequenced below  
**45 minutes prior to PACLitaxel: dexamethasone 20 mg IV** in 50 mL NS over 15 minutes  
**30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV** in 50 mL NS over 15 minutes and **famotidine 20 mg IV** in 100 mL NS over 15 minutes (Y-site compatible)
- Prior infusion reaction to dostarlimab: administer PACLitaxel premedications prior to dostarlimab  
**45 minutes prior to dostarlimab: dexamethasone 20 mg IV** in 50 mL NS over 15 minutes  
**30 minutes prior to dostarlimab: diphenhydrAMINE 50 mg IV** in 50 mL NS over 15 minutes and **famotidine 20 mg IV** in 100 mL NS over 15 minutes (Y-site compatible)
- acetaminophen 325 to 975 mg PO** 30 minutes prior to dostarlimab

|                                  |                          |   |
|----------------------------------|--------------------------|---|
| AND select ONE of the following: | <input type="checkbox"/> | <b>ondansetron 8 mg PO</b> 30 to 60 minutes prior to CARBOplatin  |
|                                  | <input type="checkbox"/> | <b>aprepitant 125 mg PO</b> 30 to 60 minutes prior to CARBOplatin, and <b>ondansetron 8 mg PO</b> 30 to 60 minutes prior to CARBOplatin |
|                                  | <input type="checkbox"/> | <b>netupitant-palonosetron 300 mg-0.5 mg PO</b> 30 to 60 minutes prior to CARBOplatin   |

If additional antiemetic required:

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

**CYCLE 7 to 23:**

For prior dostarlimab infusion reaction:

- 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:

Continued on Page 2

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

**PROTOCOL CODE: GOEAVDCAT**

**DATE:**

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

**TREATMENT:**

Cycle \_\_\_\_\_ (Cycles 1 to 6):

**dostarlimab 500 mg IV in 100 mL NS over 30 minutes using a 0.2 micron in-line filter\* on Day 1**

**PACLitaxel**  175 mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg **on Day 1**  
IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use Non DEHP tubing with 0.2 micron in-line filter\*)

**CARBOplatin AUC**  6 *or*  5 (select one) x (GFR + 25) = \_\_\_\_\_ mg **on Day 1**

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg  
IV in 100 to 250 mL NS over 30 minutes

\* use separate infusion line and filter for each drug

Cycle \_\_\_\_\_ (Cycles 7 to 23):

**dostarlimab 1000 mg IV in 100 mL NS over 30 minutes using a 0.2 micron in-line filter on Day 1 every 6 weeks**

**RETURN APPOINTMENT ORDERS**

- Return in **three** weeks for Doctor and Cycle \_\_\_\_\_ (Cycles 1 to 6)
- Return in **three** weeks for Doctor and Cycle 7
- Return in **six** weeks for Doctor and Cycle \_\_\_\_\_ (Cycles 8 to 23)
- Last Cycle. Return in \_\_\_\_\_ week(s)

**CBC & Diff, creatinine, ALT, alkaline phosphatase, total bilirubin, 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
- free T3 and free T4  lipase  morning serum cortisol  random glucose
- magnesium  calcium  creatine kinase  LDH  GGT  troponin
- serum ACTH levels  testosterone  estradiol  FSH  LH
- CA 125  CA 15-3  CA 19-9  CEA
- Weekly nursing assessment for (specify concern): \_\_\_\_\_
- Other consults
- See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**