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: GOEAVPCAT

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

May proceed with pembrolizumab 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. RN/Pharmacist to confirm _____.

CYCLES 1 to 6:

☐ No prior infusion reaction to pembrolizumab: 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 pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab
45 minutes prior to pembrolizumab:
dexamethasone 20 mg IV in 50 mL NS over 15 minutes
30 minutes prior to pembrolizumab:
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 pembrolizumab

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 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
☐ **Other:**

CYCLES 7 to 20:

For prior pembrolizumab 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

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

DATE:

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

TREATMENT:

☐ **Cycle _____ (Cycles 1 to 6):**

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		

PACLitaxel ☐ **175 mg/m²** x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
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)** x = _____ mg
☐ 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 20):**

pembrolizumab 4 mg/kg x _____ kg = _____ mg **(maximum 400 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		

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 20)
☐ 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**
☐ **GGT** ☐ **creatine kinase** ☐ **troponin** ☐ **magnesium** ☐ **calcium** ☐ **LDH**
☐ **CA 125** ☐ **CA 15-3** ☐ **CA19-9** ☐ **CEA**
☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**
☐ **Weekly nursing assessment for (specify concern): _____**
☐ **Other 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**

PEMBROLIZUMAB DOSE BANDING TABLE (4 mg/kg capped 400 mg)

Ordered Dose (mg)		Rounded dose (mg)
From:	**To:**	
Less than 137.5		**Pharmacy prepares specific dose**
137.5	162.49	**150**
162.5	187.49	**175**
187.5	221.49	**200**
221.5	242.49	**225**
242.5	264.49	**250**
264.5	284.49	**275**
284.5	332.49	**300**
332.5	374.49	**350**
374.5	400	**400**