PROTOCOL CODE: GOEAVPPNC

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

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 NAB 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 of oral medications. RN/Pharmacist to confirm _____.

CYCLES 1 to 6:

For prior pembrolizumab infusion reaction:
☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to pembrolizumab
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to pembrolizumab
☐ **hydrocortisone 25 mg** IV 30 minutes prior to pembrolizumab

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 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

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

☐ **Other:**

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 NAB 260 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____mg/m^2 = _____ mg
IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter*)
Pharmacist to select **dose band** per last page of PPO. Complete table below (please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
PACLitaxel NAB		

CARBOplatin AUC ☐ **6** *or* ☐ **5** *(select one)* **x (GFR + 25)** = _____ 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
☐ **GGT** ☐ **morning serum cortisol** ☐ **lipase** ☐ **random glucose** ☐ **troponin**
☐ **creatine kinase** ☐ **free T3 and free T4** ☐ **serum ACTH levels** ☐ **testosterone**
☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **magnesium** ☐ **calcium** ☐ **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:

PACLitaxel NAB DOSE BANDING TABLE

Ordered Dose (mg)		Rounded dose (mg)
From:	**To:**	
Less than 96		**Pharmacy prepares specific dose**
96	104.49	**100**
104.5	108.49	**105**
108.5	115.49	**110**
115.5	125.49	**120**
125.5	135.49	**130**
135.5	145.49	**140**
145.5	155.49	**150**
155.5	165.49	**160**
165.5	177.49	**170**
177.5	190.49	**185**
190.5	210.49	**200**
210.5	230.49	**220**
230.5	250.49	**240**
250.5	270.49	**260**
270.5	286.49	**275**
286.5	314.49	**300**
314.5	329.49	**315**
329.5	344.49	**330**
344.5	362.49	**345**
362.5	388.49	**370**
388.5	419.49	**400**
419.5	439.49	**420**
439.5	459.49	**440**
459.5	479.49	**460**
479.5	499.49	**480**
499.5	524.49	**500**
524.5	566.49	**540**
566.5	596.49	**580**
596.5	630.49	**600**
630.5	683.49	**650**
More than 683.49		**Pharmacy prepares specific dose**

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**