

**PROTOCOL CODE: UGOCXCATBP**

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A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

<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>
<b>Date of Previous Cycle:</b>				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff on day of treatment</b>				
<p>May proceed with doses as written if within 96 hours <b>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, 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, BP less than or equal to 150/100, and urine dipstick for protein negative or 1+.</b></p>				
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____				
<b>Proceed with treatment based on blood work from</b> _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.				
<input type="checkbox"/> No prior infusion reaction to pembrolizumab: administer premedications as sequenced below <u><b>45 minutes prior to PACLitaxel:</b></u> <b>dexamethasone 20 mg IV</b> in 50 mL NS over 15 minutes <u><b>30 minutes prior to PACLitaxel:</b></u> <b>diphenhydrAMINE 50 mg IV</b> in 50 mL NS over 15 minutes and <b>famotidine 20 mg IV</b> in 100 mL NS over 15 minutes (Y-site compatible)				
<input type="checkbox"/> Prior infusion reaction to pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab <u><b>45 minutes prior to pembrolizumab:</b></u> <b>dexamethasone 20 mg IV</b> in 50 mL NS over 15 minutes <u><b>30 minutes prior to pembrolizumab:</b></u> <b>diphenhydrAMINE 50 mg IV</b> in 50 mL NS over 15 minutes and <b>famotidine 20 mg IV</b> in 100 mL NS over 15 minutes (Y-site compatible)				
<input type="checkbox"/> <b>acetaminophen 325 to 975 mg PO</b> 30 minutes prior to pembrolizumab				
AND select <b>ONE</b> 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:				
<input type="checkbox"/> <b>OLANzapine</b> <input type="checkbox"/> <b>2.5 mg</b> or <input type="checkbox"/> <b>5 mg</b> or <input type="checkbox"/> <b>10 mg</b> (select one) PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> <b>Other:</b>				
Continued on page 2				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				<b>UC:</b>

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DATE:

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

**TREATMENT:**

**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 pages of PPO. Complete table below (please print)**

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

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

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg/m<sup>2</sup> 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 5 x (GFR + 25)** x = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg

IV in 100 to 250 mL NS over 30 minutes.

Blood pressure measurement pre-bevacizumab dose.

**bevacizumab**  **15 mg/kg** or  \_\_\_\_\_ mg/kg (*select one*) x \_\_\_\_\_ kg = \_\_\_\_\_ mg

IV in 100 to 250 mL NS over 30 minutes.

(Blood pressure measurement post-bevacizumab infusion for first 3 cycles)

**Pharmacist to select brand per Provincial Systemic Therapy Policy III-190 and dose band per last page of PPO. Complete table below (please print)**

Drug	Brand	Dose Band (mg)	Pharmacist Initial and Date
bevacizumab			

\* use separate infusion line and filter for each drug

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**  
**UC:**

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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
Return in <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in three weeks for GOCXBP or GOCXBP6 (to continue pembrolizumab with or without bevacizumab)	
<p><b>CBC &amp; Diff, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle.</b></p> <input type="checkbox"/> <b>24 hr 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>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 childbearing 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>random glucose</b>   <input type="checkbox"/> <b>GGT</b>   <input type="checkbox"/> <b>creatine kinase</b>  <input type="checkbox"/> <b>magnesium</b>   <input type="checkbox"/> <b>calcium</b>   <input type="checkbox"/> <b>troponin</b>   <input type="checkbox"/> <b>LDH</b>  <input type="checkbox"/> <b>CA125</b>   <input type="checkbox"/> <b>CA 15-3</b>   <input type="checkbox"/> <b>CA 19-9</b>   <input type="checkbox"/> <b>CEA</b>   <input type="checkbox"/> <b>SCC</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></p> <p><input type="checkbox"/> <b>Weekly nursing assessment for (specify concern):</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>

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**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

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**Bevacizumab Dose Banding Table**

Ordered Dose (mg)		Rounded dose (mg)
From:	To:	
Less than 188		<b>Pharmacy prepares specific dose</b>
188	221.49	<b>200</b>
221.5	236.49	<b>225</b>
236.5	260.49	<b>250</b>
260.5	286.49	<b>275</b>
286.5	332.49	<b>300</b>
332.5	387.49	<b>350</b>
387.5	443.49	<b>400</b>
443.5	474.49	<b>450</b>
474.5	554.49	<b>500</b>
554.5	665.49	<b>600</b>
665.5	776.49	<b>700</b>
776.5	887.49	<b>800</b>
887.5	999.49	<b>900</b>
999.5	1099.49	<b>1000</b>
1099.5	1199.49	<b>1100</b>
1199.5	1299.49	<b>1200</b>
1299.5	1399.49	<b>1300</b>
1399.5	1499.49	<b>1400</b>
1499.5	1599.49	<b>1500</b>
1599.5	1699.49	<b>1600</b>
1699.5	1799.49	<b>1700</b>
1799.5	1899.49	<b>1800</b>
1899.5	1999.49	<b>1900</b>
1999.5	2099.49	<b>2000</b>
2099.5	2199.49	<b>2100</b>
2199.5	2299.49	<b>2200</b>
2299.5	2399.49	<b>2300</b>
More than 2399.49		<b>Pharmacy prepares specific dose</b>