

PROTOCOL CODE: UGOCXCATP

Page 1 of 3

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

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:			
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment			
May proceed with doses as written if within 96 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 100 x 10⁹/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			
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____			
Proceed with treatment based on blood work from _____			
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.			
<input type="checkbox"/> No prior infusion reaction to pembrolizumab: administer premedications as sequenced below			
<u>45 minutes prior to PACLitaxel:</u>			
dexamethasone 20 mg IV in 50 mL NS over 15 minutes			
<u>30 minutes prior to PACLitaxel:</u>			
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)			
<input type="checkbox"/> Prior infusion reaction to pembrolizumab: administer PACLitaxel premedications prior to pembrolizumab			
<u>45 minutes prior to pembrolizumab:</u>			
dexamethasone 20 mg IV in 50 mL NS over 15 minutes			
<u>30 minutes prior to pembrolizumab:</u>			
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)			
<input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to pembrolizumab			
AND select ONE of the following:	<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin	
	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin	
	<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin	
If additional antiemetic required:			
<input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin			
<input type="checkbox"/> Other:			
Continued on Page 2			
DOCTOR'S SIGNATURE:			SIGNATURE:
			UC:

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Page 2 of 3

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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 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 5 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

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____

Last Cycle. Return in three weeks for GOCXBP or GOCXBP6 (to continue pembrolizumab)

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 SCC

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:

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Page 3 of 3

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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