



Provincial Health Services Authority

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/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

# PROTOCOL CODE: HNAJPMBPRT (Inpatient Long Hydration – Cycle 3)

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## 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: \_\_\_\_\_

May proceed with CISplatin as written if within 96 hours **ANC greater than or equal to  $1.5 \times 10^9/L$ , platelets greater than or equal to  $100 \times 10^9/L$ , creatinine clearance greater than or equal to 60 mL/minute.**

May proceed with pembrolizumab as written if within 96 hours **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, creatinine less than or equal to 1.5 times the upper limit of normal and less than or equal to 1.5 times baseline**

Dose modification for:  Hematology  Other Toxicity \_\_\_\_\_

Proceed with treatment based on blood work from \_\_\_\_\_

### INPATIENT TREATMENT

- Admit to inpatient bed
- Refer to inpatient ward policies and procedures for additional orders (e.g., bowel regimen, VTE prophylaxis, etc.)

### ON ADMISSION:

- CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, calcium, albumin, magnesium, TSH

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm \_\_\_\_\_.

**dexamethasone 12 mg** PO/IV 30 to 60 minutes prior to CISplatin and then 4 mg PO/IV q12h x 6 doses  
**aprepitant 125 mg** PO 30 to 60 minutes prior to CISplatin and 80 mg PO daily on Days 2 and 3  
**ondansetron 8 mg** PO 30 to 60 minutes prior to CISplatin and then 8 mg PO/IV q12h x 6 doses

If additional antiemetic required:

- OLANzapine**  **2.5 mg** or  **5 mg** or  **10 mg** (select one) PO 30 to 60 minutes prior to CISplatin  
 **Other:** \_\_\_\_\_

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

### SUPPORTIVE CARE MEDICATIONS:

- LORazepam 1 mg** SL q4-6h PRN nausea, sleep or restlessness  
 **prochlorperazine 10 mg** PO q4-6h PRN nausea  
 **diphenhydrAMINE 25-50 mg** PO/IV q4-6h PRN  
 **Other:** \_\_\_\_\_

**DOCTOR'S SIGNATURE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**UC:** \_\_\_\_\_



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**DATE:**

CISplatin is only to be administered if concurrent with radiation

**TREATMENT:**

**pembrolizumab 2 mg/kg** x \_\_\_\_\_ kg = \_\_\_\_\_ mg (**max. 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		

**Hydration prior to CISplatin:**

D5W-1/2 NS 1000 mL with potassium chloride 20mmol plus magnesium sulfate 2 g IV over 3 hours.

Prior to beginning CISplatin, urine output must be greater than or equal to 300 mL in 3 hours. May repeat prehydration x 1000 mL to ensure urine output greater than 300 mL in 3 hours. If urine output not adequate after 2 L, notify physician.

**When urine output is adequate, give:**

**CISplatin 100 mg/m<sup>2</sup>** x BSA = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

IV in NS 1000 mL with mannitol 30 g and potassium chloride 10 mmol over 2 hours.

**Hydration post-CISplatin:**

D5W-1/2 NS with potassium chloride 20 mmol/L + magnesium sulfate 2 g/L IV at 200 mL/h for 12hours.

Measure intake and output every 3 hours while on IV. If output less than 300 mL during a 3-hour period, increase IV to 300 mL/hour for 3 hours. If urine output still less than 300 mL in a subsequent 3-hour period give **furosemide 20 mg IV x 1**. If output still not adequate, notify physician. May discontinue IV and discharge after post hydration if urine output adequate and patient not vomiting.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**



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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book outpatient treatment on Day 1.	
<b>CBC &amp; Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH</b> prior to each treatment	
If clinically indicated:	
<input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>chest X-ray</b>	
<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>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>	
<input type="checkbox"/> <b>Weekly nursing assessment</b> for (specify concern): _____	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Consults:	
<input type="checkbox"/> See general orders sheet for additional requests.	
<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	<b>75</b>
80.5	92.49	<b>85</b>
92.5	110.49	<b>100</b>
110.5	137.49	<b>125</b>
137.5	162.49	<b>150</b>
162.5	187.49	<b>175</b>
187.5	200	<b>200</b>