PROTOCOL CODE: BRAVSG

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, platelets** day of treatment
May proceed with doses as written on **Day 1** if within 72 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L**
May proceed with doses as written on **Day 8** if within 24 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.
dexamethasone ☐ **8 mg or** ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to sacituzumab govitecan
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to sacituzumab govitecan, and **ondansetron 8 mg** PO 30 to 60 minutes prior to sacituzumab govitecan
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to sacituzumab govitecan

If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment

30 Minutes Prior to treatment:

diphenhydrAMINE 50 mg IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

acetaminophen 325 to 975 mg PO

For prior cholinergic response:
☐ **Prophylactic atropine 0.3** mg subcutaneously

For prior infusion reaction:
☐ **hydrocortisone 100 mg** IV 30 minutes prior to treatment
☐ **Other:**

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

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE # 1 Day 1**

sacituzumab govitecan 10 mg/kg x _____ kg = _____ mg
☐ Dose Modification: _____% = _____ mg/kg = _____ mg
IV in 100 to 1000 mL NS over 3 hours on **Day 1**. Observe for 30 minutes post-infusion

☐ **CYCLE # 1 Day 8**

sacituzumab govitecan 10 mg/kg x _____ kg = _____ mg
☐ Dose Modification: _____% = _____ mg/kg = _____ mg
IV in 100 to 1000 mL NS over 1 hour on **Day 8**. Observe for 30 minutes post-infusion.

**** SEE PAGE 2 FOR CYCLE 2 ONWARDS ****

DOCTOR SIGNATURE: **SIGNATURE:**
UC:

DOCTOR'S ORDERS	**Ht_____cm Wt_____kg BSA_____m²**	
DATE:	**To be given:**	**Cycle #:**

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

CHEMOTHERAPY (Continued):

OR

☐ **CYCLE # 2 onwards**

sacituzumab govitecan 10 mg/kg x _____ kg = _____ mg

☐ Dose Modification: _____% = _____ mg/kg = _____ mg

IV in 100 to 1000 mL NS over 1 hour on **Days 1 and 8**. Observe for 30 minutes post-infusion.

Counsel patient to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO with each episode of diarrhea until diarrhea free x 12 hours.

atropine 0.3 to 0.6 mg subcutaneously or IV prn repeat up to 1.2 mg for diarrhea, abdominal cramps, rhinorrhea, increased salivation, lacrimation, diaphoresis or flushing.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle_____. Book chemo Day 1 and Day 8. ☐ Last Cycle. Return in _____ weeks.	
CBC & Diff, Platelets prior to each treatment (for Day 1 and Day 8) If clinically indicated: ☐ **Total Bilirubin** ☐ **Direct Bilirubin** ☐ **Alk Phos** ☐ **ALT** ☐ **LDH** ☐ **Albumin** ☐ **Total Protein** ☐ **Glucose** ☐ **Creatinine** ☐ **BUN** ☐ **Sodium** ☐ **Potassium** ☐ **Calcium** ☐ **Magnesium** ☐ **Phosphorous** ☐ **CA 15-3** ☐ **ECG** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR SIGNATURE:	**SIGNATURE:** **UC:**