# PROTOCOL CODE: BRPCTAC



## 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

On Day 1: may proceed with doses as written if within 48 h: **ANC greater than or equal to 1.5 x $10^9$/L, Platelets greater than or equal to 90 x $10^9$/L, ALT less than or equal to 3 times the upper limit of normal, 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 the baseline.**

On Days 8 and 15: may proceed with doses as written if within 24 h: **ANC greater than or equal to 1.5 x $10^9$/L, Platelets greater than or equal to 90 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 _____.

**CYCLE # 1 to 8** (pembrolizumab premedications)

For prior pembrolizumab infusion reaction (and receiving PACLitaxel premedications):

☐ Give PACLitaxel premedications prior to pembrolizumab infusion

For prior pembrolizumab infusion reaction (if **not** receiving PACLitaxel premedications):

☐ **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

☐ **CYCLE # 1 to 4**

**45 Minutes Prior to PACLitaxel:**
**dexamethasone 10 mg** IV in NS 50 mL over 15 minutes

**30 Minutes Prior to PACLitaxel:**
**diphenhydrAMINE 25 mg** IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ No premedication to PACLitaxel required (see protocol for guidelines)

**If not receiving** IV dexamethasone for PACLitaxel, give: **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 CARBOplatin |

☐ **CYCLE # 5 to 8**

**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 treatment |
| | ☐ | **aprepitant 125 mg** PO 30 to 60 minutes prior to treatment, and **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment |
| | ☐ | **netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment |

**CYCLE #1 to 8** - If additional antiemetic required:

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

*** SEE PAGE 2 FOR CHEMOTHERAPY ORDERS ***

**DOCTOR'S SIGNATURE:** **SIGNATURE:** **UC:**

**PROTOCOL CODE: BRPCTAC**



## DOCTOR'S ORDERS

**Ht**_____**cm** **Wt**_____**kg** **BSA**_____**m²**

**DATE:** **To be given:** **Cycle #:**

****Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4****

### TREATMENT:

☐ **CYCLE #_____ (Cycle 1-4)**

**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* **Day 1 only**

**PACLitaxel** ☐ **80 mg/m²** OR ☐ **_____ mg/m²** (select one) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour on **Days 1, 8 and 15** (use non-DEHP tubing with 0.2 micron in-line filter*)

**CARBOplatin AUC** ☐ **5 or** ☐ **4** (select one) **x (GFR + 25)** = _____ mg

☐ Dose Modification: _____ % = _____ mg

IV in 100 to 250 mL NS over 30 minutes on **Day 1 only**

* Use separate infusion line and filter for each drug

***OR***

☐ **CYCLE #_____ (Cycle 5-8)**

**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

**DOXOrubicin 60 mg/m²** x BSA = _____mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV push

**cyclophosphamide 600 mg/m²** x BSA =_____mg

☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

# DOCTOR'S ORDERS

**DATE:**

## RETURN APPOINTMENT ORDERS

| | |
|---|---|
| ☐ Return in **three** weeks for Doctor and Cycle _____ (Book chemo room weekly x 3 for cycles 1-4; book chemo room every three weeks for cycles 5-8, cycle 5 to start week 13)<br>☐ Last Cycle. Return in **three** weeks for BRAJPEM (to continue single agent pembrolizumab)<br>☐ Last Cycle. Return in _____ week(s). | |
| Cycles 1 to 4:<br>**CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH** prior to each cycle.<br><br>**CBC & Diff, Platelets** prior to treatment on Days 8 and 15.<br><br>Cycles 5 to 8:<br>**CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH** prior to each cycle.<br><br>If clinically indicated: ☐ **ECG** ☐ **Chest X-ray**<br>☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential<br>☐ **GGT** ☐ **FSH** ☐ **LH** ☐ **Glucose**<br>☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **creatine kinase**<br>☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol**<br>☐ **Weekly nursing assessment**<br>☐ **Other tests:**<br>☐ **Consults:**<br>☐ **See general orders sheet for additional requests.** | |
| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |