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 and according to acceptable standards of care

PROTOCOL CODE: GOCXCPNBP

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 on** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/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+.**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

For prior pembrolizumab infusion reaction:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to pembrolizumab
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to pembrolizumab
☐ **hydrocortisone 25 mg** IV 30 minutes prior to pembrolizumab

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 to CARBOplatin

If additional antiemetic required:

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

☐ **Other:**

Continued on page 2

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DOCTOR'S ORDERS

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

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

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*

PACLitaxel NAB (ABRAXANE) 260 mg/m² x BSA = _____mg
☐ Dose Modification: _____% = _____mg
IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron 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 (first infusion over 1 hour).
(Blood pressure measurement post-bevacizumab infusion for first 3 cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
bevacizumab		

* use separate infusion line and filter for each drug

DOCTOR'S SIGNATURE:

SIGNATURE:
UC:

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PROTOCOL CODE: GOCXCPNBP

DATE: Page 3 of 3	
RETURN APPOINTMENT ORDERS	
Return in **three** weeks for Doctor and Cycle _____ ☐ Last Cycle. Return in three weeks for GOCXPB or GOCXPB6 (to continue pembrolizumab with or without bevacizumab)	
CBC & Diff, Platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle. ☐ **24 hr urine for total protein** 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 ☐ **INR** weekly ☐ **INR** prior to next cycle If clinically indicated: ☐ **ECG** ☐ **Chest X-ray** ☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential ☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose** ☐ **GGT** ☐ **total protein** ☐ **albumin** ☐ **creatine kinase** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **Weekly nursing assessment** ☐ **Other consults** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**