PROTOCOL CODE: ULUAVPPPMB

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

DOCTOR'S ORDERS

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

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 if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, Creatinine Clearance greater than or equal to 60 mL/minute (if using CISplatin),** 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, bilirubin less than or equal to 1.5 times the upper limit of normal**

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 4 mg PO bid for 3 days starting one day prior to each treatment

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment **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
☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment

Ensure patient is taking **folic acid** and has had **vitamin B12** injection starting at least 7 days prior to first cycle, and to continue while on treatment, until 21 days after last pemetrexed dose.

For prior 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

****Have Hypersensitivity Reaction Tray & Protocol Available****

HYDRATION:

1000 mL NS over 1 hour prior to CISplatin

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DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:

CHEMOTHERAPY:

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

pemetrexed 500 mg/m² x BSA = _____ mg

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

IV in 100 mL NS over 10 minutes (may be given during prehydration)

Select one:

☐ **CISplatin 75 mg/m²** x BSA = _____ mg

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

IV in 500 mL NS, with potassium chloride 20 mEq, magnesium sulphate 1 g and mannitol 30 g over 1 hour

OR

☐ **CARBOplatin AUC 5 x (GFR + 25)** = _____ mg IV in 100 to 250 mL NS over 30 minutes

RETURN APPOINTMENT ORDERS

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

☐ Last Cycle. Return in _____ week(s)

CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH prior to each treatment

CBC & Diff, Platelets weekly during Cycles 1 and 2

Vitamin B12 injection required every 9 weeks. Patient to obtain supply.

☐ This patient to receive injection in clinic. Next injection due by _____.

If clinically indicated: ☐ **ECG** ☐ **Chest X-ray**

☐ **serum HCG** or ☐ **urine HCG** (select one) – required for woman of child bearing potential

☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **Glucose**

☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**

☐ **Weekly nursing assessment**

☐ **Other consults**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: