CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

pembrolizumab 2 mg/kg - PACLitaxel 175 - CISplatin 50 - Zirabev® (bevacizumab) 15 mg/kg Regimen: (Part I) Cycles 1-6

Name:

HCN:

Date of Birth:

ARIA Protocol Name: pembrolizumab2 PACLitaxel175 CISplatin50 bevacizumab15

Adult Chemotherapy - Gynecologic Oncology

Persistent, Recurrent or Metastatic Cervical Cancer Treatment

CC5380 0348 06 2023

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 21 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.0 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.
- Dipstick urine or laboratory urinalysis for protein assessed.
- Thyroid function assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **45 minutes prior to PACLitaxel: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1

☐ **30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV** in 50 mL normal saline over 15 minutes on day 1

Administer concurrently with famotidine via y-site

☐ **30 minutes prior to PACLitaxel: famotidine 20 mg IV** in 100 mL normal saline over 15 minutes on day 1

Administer concurrently with diphenhydrAMINE via y-site

☐ **fosaprepitant 150 mg IV** in 150 mL normal saline over 30 minutes on day 2

☐ **ondansetron 8 mg PO** on day 2

☐ **dexamethasone 8 mg PO** on day 2

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **sodium chloride 0.9% 1000 mL IV** hydration over 60 minutes pre-CISplatin on day 2.

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

Nurse's Name: _____ Date: _____DD/MONTH/YYYY_____ Time: _____

Nurse's Signature: _____

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Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 2 mg/kg - PACLitaxel 175 - CISplatin 50 - Zirabev® (bevacizumab) 15 mg/kg Regimen: (Part II) Cycles 1-6

ARIA Protocol Name: pembrolizumab2 PACLitaxel175 CISplatin50 bevacizumab15

Adult Chemotherapy - Gynecologic Oncology

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X Weight (kg) **= _____ mg (maximum dose 200mg)**

IV in 50 mL normal saline over 30 minutes on day 1

☐ **PACLitaxel 175 mg/m²** X BSA = _____ **mg** on day 1

☐ Dose modification: **PACLitaxel 175 mg/m²** X BSA - _____% = _____ **mg**

IV in 500 mL normal saline PVC Free over 180 minutes on day 1

☐ **CISplatin 50 mg/m²** X BSA **= _____ mg** + **mannitol 25 grams**

☐ Dose modification: **CISplatin 50 mg/m²** X BSA - _____% =_____ **mg** + **mannitol 25 grams**

IV in 500 mL normal saline infused at 1 mg/min on day 2

☐ **Zirabev® (bevacizumab) 15 mg/kg** X weight (kg) = _____ **mg** on day 2

☐ Dose modification: **Zirabev® (bevacizumab) 15 mg/kg** X weight (kg) - _____% = _____ **mg**

IV in 100 mL normal saline on day 1 over:

- **60** minutes during **Cycle 1**;
- If tolerated without reaction – **30** minutes during **Cycle 2** and all other cycles

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **magnesium sulfate 2 grams and potassium chloride 20 mEq IV** in 1000 mL normal saline over 120 minutes post-CISplatin on day 2

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Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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