



Provincial Health Services Authority

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: SMMCCAIVE

DOCTOR'S ORDERS		Wt _____ kg
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
DATE:	To be given:	Cycle #:
Date of Previous Cycle:		
<input type="checkbox"/> Delay treatment _____ week(s)		
May proceed with doses as written if within 96 hours 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 X baseline.		
Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.		
For first 4 cycles: 30 minutes prior to treatment		
diphenhydrAMINE 50 mg IV in 50 mL NS over 20 min and acetaminophen 650 mg PO		
Then as indicated based on previous reaction:		
<input type="checkbox"/> diphenhydrAMINE 50 mg IV in 50 mL NS over 20 min (30 minutes prior to avelumab)		
<input type="checkbox"/> acetaminophen 650 mg PO 30 minutes prior to avelumab		
<input type="checkbox"/> other:		
Have Hypersensitivity Reactions Tray and Protocol Available		
TREATMENT: <input type="checkbox"/> Repeat in two weeks		
avelumab 10 mg/kg x _____ kg = _____ mg		
IV in 250 mL NS over 1 hour using a 0.2 micron in-line filter		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in two weeks for Doctor and Cycle _____		
<input type="checkbox"/> Return in four weeks for Doctor and Cycles _____ and _____. Book for 2 cycles.		
<input type="checkbox"/> Last cycle. Return in _____ week(s)		
CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, random glucose prior to each treatment		
If clinically indicated: <input type="checkbox"/> ECG <input type="checkbox"/> Chest X-ray <input type="checkbox"/> CT scan _____		
<input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of child bearing potential		
<input type="checkbox"/> Free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol		
<input type="checkbox"/> serum ACTH levels <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> Glucose (fasting)		
<input type="checkbox"/> Weekly nursing assessment		
<input type="checkbox"/> Other consults:		
<input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: