

**PROTOCOL CODE: BRAJPEM**

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<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>
Date of Previous Cycle: _____		
Indicate the number of pembrolizumab doses patient has received together with chemotherapy (not as single agent) to date: _____		
<input type="checkbox"/> Delay treatment _____ week(s)		
May proceed with doses as written if within 96 hours <b>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</b> , creatinine <b>less than or equal to 1.5 times the upper limit of normal and less than or equal to 1.5 times the baseline.</b>		
Proceed with treatment based on blood work from _____		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. For prior infusion reaction:		
<input type="checkbox"/> <b>diphenhydrAMINE 50 mg</b> PO 30 minutes prior to treatment <input type="checkbox"/> <b>acetaminophen 325 to 975 mg</b> PO 30 minutes prior to treatment <input type="checkbox"/> <b>hydrocortisone 25 mg</b> IV 30 minutes prior to treatment		
<b>TREATMENT:</b> <input type="checkbox"/> Repeat in three weeks <b>pembrolizumab 2 mg/kg</b> x _____ kg = _____ mg (max. 200 mg) IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>three weeks</b> for Doctor and Cycle _____ <input type="checkbox"/> Return in <b>six weeks</b> for Doctor and Cycles _____ and _____. Book treatment x 2 cycles. <input type="checkbox"/> Last cycle. Return in _____ week(s)		
<b>CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH</b> prior to each treatment  If clinically indicated: <input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>Chest X-ray</b> <input type="checkbox"/> <b>serum HCG</b> or <input type="checkbox"/> <b>urine HCG</b> – required for woman of child bearing potential <input type="checkbox"/> <b>Free T3 and free T4</b> <input type="checkbox"/> <b>lipase</b> <input type="checkbox"/> <b>morning serum cortisol</b> <input type="checkbox"/> <b>creatinine kinase</b> <input type="checkbox"/> <b>serum ACTH levels</b> <input type="checkbox"/> <b>testosterone</b> <input type="checkbox"/> <b>estradiol</b> <input type="checkbox"/> <b>FSH</b> <input type="checkbox"/> <b>LH</b> <input type="checkbox"/> <b>glucose</b> <input type="checkbox"/> <b>Weekly nursing assessment</b> <input type="checkbox"/> <b>Other consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>