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: UGIAVPEM6

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)

May proceed with doses as written if within 96 hours **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,** 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 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

CHEMOTHERAPY:

pembrolizumab 4 mg/kg x _____ kg = _____mg **(max. 400 mg)** every 6 weeks

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

RETURN APPOINTMENT ORDERS

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

☐ Last cycle. Return in _____ **week(s)**

CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to each treatment

If clinically indicated: ☐ **CEA** ☐ **CA19-9** ☐ **ECG** ☐ **chest x-ray**
☐ **serum HCG or** ☐ **urine HCG** – required for woman of childbearing potential
☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose**
☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **creatine kinase** ☐ **troponin**
☐ **Weekly nursing assessment**
☐ **Other consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: