

PROTOCOL CODE: UGIAVPEM

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

DOCTOR'S ORDERS		Ht _____ cm Wt _____ kg BSA _____ m ²
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 , 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: <input type="checkbox"/> diphenhydramine 50 mg PO 30 minutes prior to treatment <input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to treatment <input type="checkbox"/> hydrocortisone 25 mg IV 30 minutes prior to treatment		
CHEMOTHERAPY: <input type="checkbox"/> Repeat in three weeks 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		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in six weeks for Doctor and Cycles _____ and _____. Book chemo x 2 cycles. <input type="checkbox"/> Last cycle. Return in _____ week(s)		
CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to each treatment If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA19-9 <input type="checkbox"/> ECG <input type="checkbox"/> chest x-ray <input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of childbearing potential <input type="checkbox"/> free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> random glucose <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"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> creatinine kinase <input type="checkbox"/> troponin <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: