PROTOCOL CODE: GUAVPEMAX6

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:

☐ Delay treatment _____ week(s)

During pembrolizumab and aXitinib combination treatment ONLY:
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 times the baseline, and if ordered **urine protein** **less than** **1 g/24 h.**
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

For prior pembrolizumab 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

TREATMENT:

☐ Cycles 1 to 18 (pembrolizumab and aXitinib combination treatment)

pembrolizumab 4 mg/kg x _____ kg = _____mg (max. 400 mg)
IV in NS 50 mL over 30 minutes using a 0.2 micron in-line filter

aXitinib ☐ **5 mg or** ☐ **_____ mg** (select one) PO twice daily. Mitte: ☐ 42 days or _____ days.

☐ Cycles 19 onwards (aXitinib treatment)

aXitinib ☐ **5 mg or** ☐ **_____ mg** (select one) PO twice daily. Mitte: ☐ 42 days or _____ days.

RETURN APPOINTMENT ORDERS

☐ Return in **six weeks** for Doctor and Cycle _____
☐ Return in _____ weeks for Doctor and Cycle _____
☐ Last cycle. Return in _____ **week(s)**

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DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

Date:

☐ Cycles 1 to 18 (pembrolizumab and aXitinib combination treatment)

CBC & Diff, sodium, potassium, creatinine, ALT, alkaline phosphatase, total bilirubin, LDH, uric acid, TSH, dipstick urine or laboratory urinalysis for protein prior to each cycle

If clinically indicated:

☐ **24 hour urine protein within 4 days prior to next cycle for laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+**

☐ **MUGA scan OR** ☐ **echocardiogram** ☐ **ECG** ☐ **chest x-ray**

☐ **serum HCG OR** ☐ **urine HCG** (required for woman of child bearing potential)

☐ **free T3 and T4** ☐ **morning serum cortisol** ☐ **serum ACTH levels**

☐ **FSH** ☐ **LH** ☐ **estradiol** ☐ **testosterone**

☐ **albumin** ☐ **GGT** ☐ **total protein** ☐ **lipase**

☐ **calcium** ☐ **phosphorus** ☐ **glucose**

☐ **C-reactive protein** ☐ **creatine kinase** ☐ **troponin**

☐ **Weekly nursing assessment**

☐ Cycles 19 onwards (aXitinib treatment)

CBC & Diff, creatinine, ALT, total bilirubin, uric acid, dipstick urine or laboratory urinalysis for protein prior to each cycle

☐ TSH prior to every other cycle

If clinically indicated:

☐ **24 hour urine protein within 4 days prior to next cycle for laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+**

☐ **sodium**	☐ **potassium**	☐ **calcium**	☐ **phosphorus**
☐ **albumin**	☐ **alkaline phosphatase**	☐ **GGT**	☐ **LDH**
☐ **total protein**	☐ **TSH**	☐ **MUGA scan OR**	☐ **echocardiogram**

☐ **Other tests:**

☐ **Other consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: