PROTOCOL CODE: GUAVPEML

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)

May proceed with pembrolizumab 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.

May proceed with lenvatinib as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L**, **platelets greater than or equal to 75 x 10^9/L**, **BP less than 160/100 mmHg, creatinine clearance greater than or equal to 30 mL/min**, **alkaline phosphatase or ALT less than or equal to 5 X ULN**, **total bilirubin less than or equal to 3 X ULN**, and if ordered **urine protein less than 1 g/24 h.**

Dose modification for:
☐ **Hematology** ☐ **Hypertension** ☐ **Diarrhea** ☐ **QTc prolongation** ☐ **Other Toxicity**

Proceed with treatment based on blood work from _____

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

Antiemetics per protocol

For prior infusion reaction to pembrolizumab:
☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to pembrolizumab
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to pembrolizumab
☐ **hydrocortisone 25 mg** IV 30 minutes prior to pembrolizumab

TREATMENT:

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

lenvatinib (select one)
☐ **20 mg** PO once daily
☐ **14 mg** PO once daily
☐ **10 mg** PO once daily
☐ **8 mg** PO once daily
☐ **4 mg** PO once daily

Mitte: ☐ 25 days or _____ days. **Order in increments of 5 days (only available as 5-day supply unit)**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

Date:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle_____ ☐ Please book Nurse for BP monitoring q 2 weeks x _____ ☐ Last Cycle. Return in _____ week(s)	
CBC & Diff, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, magnesium, calcium, albumin, TSH, dipstick urine or laboratory urinalysis for protein, blood pressure measurement prior to each cycle **Every two weeks for first 2 months: ALT, alkaline phosphatase, total bilirubin, albumin** During cycle 1 and 2: weekly telephone nursing assessment ☐ Cycle 3 onward: every _____ weeks telephone nursing assessment for _____ weeks 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+** ☐ **ECG** ☐ **Chest X-ray** ☐ **MUGA scan or** ☐ **echocardiogram** ☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential ☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose** ☐ **creatine kinase** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **GGT** ☐ **total protein** ☐ **phosphorus** ☐ **C-reactive protein** ☐ **troponin** ☐ **INR** ☐ **Other consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**