



Provincial Health Services Authority

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/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

PROTOCOL CODE: LUAVPPMBM

DOCTOR'S ORDERS

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

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)
- CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 96 hours ANC **greater than or equal to**  $1.5 \times 10^9/L$ , Platelets **greater than or equal to**  $100 \times 10^9/L$ , 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, 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

Dose modification for:  Hematology  Other Toxicity: \_\_\_\_\_

Proceed with treatment based on blood work from \_\_\_\_\_

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

**dexamethasone 4 mg** PO bid for 3 days starting one day prior to each treatment

Ensure patient is taking **folic acid** and has had **vitamin B12** injection starting at least 7 days prior to first cycle, and to continue while on treatment, until 21 days after last pemetrexed dose.

For prior infusion reaction to pembrolizumab:

- 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 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

**pemetrexed 500 mg/m<sup>2</sup>** x BSA = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_% = \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

IV in 100 mL NS over 10 minutes

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle \_\_\_\_\_

Last Cycle. Return in \_\_\_\_\_ week(s)

**CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH** prior to each treatment

**CBC & Diff, Platelets** weekly during Cycles 1 and 2

(continued on page 2)

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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DATE:

**Vitamin B12 injection** required every 9 weeks. Patient to obtain supply.

This patient to receive injection in clinic. Next injection due by \_\_\_\_\_.

If clinically indicated:  **ECG**  **Chest X-ray**

**serum HCG** or  **urine HCG** – required for woman of child bearing potential

**Free T3 and free T4**  **lipase**  **morning serum cortisol**  **Glucose**

**serum ACTH levels**  **testosterone**  **estradiol**  **FSH**  **LH**

**Weekly nursing assessment**

**Other consults**

**See general orders sheet for additional requests**

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SIGNATURE:

UC: