PROTOCOL CODE: SMAJPEM

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 doses as written if within 96 hours **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,** 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.

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

TREATMENT: ☐ Repeat in three weeks

pembrolizumab 2 mg/kg x _____ kg = _____ mg (max. 200 mg) every 3 weeks

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

RETURN APPOINTMENT ORDERS

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

☐ Return in **six** weeks for Doctor and Cycles _____ and _____. Book treatment x 2 cycles.

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

CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, creatine kinase prior to each treatment

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**
☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **Glucose**
☐ **troponin**

☐ **Weekly nursing assessment**

☐ **Other consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: