

PROTOCOL CODE: BRAVPEM6

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DOCTOR'S ORDERS		Wt _____ kg
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
DATE:	To be given:	Cycle #:
Date of Previous Cycle: _____		
Indicate the number of pembrolizumab doses patient has received together with chemotherapy (not as single agent) to date: _____		
<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 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:		
<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		
TREATMENT:		
pembrolizumab 4 mg/kg x _____ kg = _____ mg (maximum 400 mg) every 6 weeks		
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter		
Pharmacist to select dose band per last page of PPO. Complete table below (please print)		
Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in six weeks for Doctor and Cycle _____		
<input type="checkbox"/> Last cycle. Return in _____ week(s)		
CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, sodium, potassium, TSH, LDH, creatine kinase prior to each treatment		
If clinically indicated: <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"/> morning serum cortisol <input type="checkbox"/> creatinine kinase <input type="checkbox"/> lipase <input type="checkbox"/> GGT		
<input type="checkbox"/> free T3 and free T4 <input type="checkbox"/> serum ACTH levels <input type="checkbox"/> CA15-3 <input type="checkbox"/> troponin		
<input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> random glucose		
<input type="checkbox"/> Weekly nursing assessment for (specify concern): _____		
<input type="checkbox"/> Other consults:		
<input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC:

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PEMBROLIZUMAB DOSE BANDING TABLE (4 mg/kg capped 400 mg)

Ordered Dose (mg)		Rounded dose (mg)
From:	To:	
Less than 137.5		Pharmacy prepares specific dose
137.5	162.49	150
162.5	187.49	175
187.5	221.49	200
221.5	242.49	225
242.5	264.49	250
264.5	284.49	275
284.5	332.49	300
332.5	374.49	350
374.5	400	400