



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 and according to acceptable standards of care

PROTOCOL CODE: BRAVPEM

(Page 1 of 2)

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: _____

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:

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 (**maximum 200 mg**) every 3 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

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, sodium, potassium, TSH, LDH, creatine kinase prior to each treatment

If clinically indicated: **ECG** **chest x-ray**

serum HCG or **urine HCG** – required for woman of childbearing potential

morning serum cortisol **lipase** **GGT** **random glucose**

free T3 and free T4 **serum ACTH levels** **testosterone** **estradiol**

FSH **LH** **CA15-3** **troponin**

Weekly nursing assessment for (specify concern): _____

Other consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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(Page 2 of 2)

PEMBROLIZUMAB DOSE BANDING TABLE (2 mg/kg capped 200 mg)

Ordered Dose (mg)		Rounded dose (mg)
From:	To:	
Less than 70		Pharmacy prepares specific dose
70	80.49	75
80.5	92.49	85
92.5	110.49	100
110.5	137.49	125
137.5	162.49	150
162.5	187.49	175
187.5	200	200