

PROTOCOL CODE: BRAVPP

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DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

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** day of treatment

On Day 1: may proceed with doses as written if within 96 hours: **ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 90 x 10⁹/L, 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.**

On Days 8 and 15: may proceed with doses as written if within 48 hours: **ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 90 x 10⁹/L**

Dose modification for: **Hematology** **Other Toxicity** _____

Proceed with treatment based on blood work from _____

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

For prior pembrolizumab infusion reaction (and receiving PACLitaxel premedications):

- Give PACLitaxel premedications prior to pembrolizumab infusion

For prior pembrolizumab infusion reaction (if **not** receiving PACLitaxel premedications):

- 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

45 Minutes Prior to PACLitaxel:

dexamethasone 10 mg IV in 50 mL NS over 15 minutes

30 Minutes Prior to PACLitaxel:

diphenhydrAMINE 25 mg IV in 50 mL NS over 15 minutes and **famotidine 20 mg** IV in 100 mL NS over 15 minutes (Y-site compatible)

- No premedication to PACLitaxel required (see protocol for guidelines)

Other:

TREATMENT:

pembrolizumab 2 mg/kg x _____ kg = _____ mg (**maximum dose = 200 mg**)

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter* on **Day 1 only**

Pharmacist to select dose band per last page of PPO. Complete table below (please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

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DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE: _____	
TREATMENT: (Continued) PACLitaxel 80 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 500 mL (non-DEHP bag) NS over 60 minutes on Days 1, 8, and 15 (use non-DEHP tubing with 0.2 micron in-line filter*) * Use separate infusion line and filter for each drug	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ (Book treatment weekly x 3) <input type="checkbox"/> Last cycle. Return in _____ week(s)	
CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, creatine kinase prior to each cycle CBC & Diff prior to treatment on Days 8 and 15. 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"/> free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> troponin <input type="checkbox"/> serum ACTH levels <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> random glucose <input type="checkbox"/> CA15-3 <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 (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