

PROTOCOL CODE: GIAVPEM6

| 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: | | | | | | | | |
| <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 X 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) | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="padding: 5px;">Drug</th> <th style="padding: 5px;">Dose Band (mg)</th> <th style="padding: 5px;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">pembrolizumab</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> </tbody> </table> | Drug | Dose Band (mg) | Pharmacist Initial and Date | pembrolizumab | | | | |
| 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, ALT, total bilirubin, sodium, potassium, TSH 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"/> free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> serum ACTH levels <input type="checkbox"/> testosterone <input type="checkbox"/> estradiol <input type="checkbox"/> FSH <input type="checkbox"/> LH <input type="checkbox"/> random glucose <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> creatinine kinase <input type="checkbox"/> troponin <input type="checkbox"/> CEA <input type="checkbox"/> CA19-9 <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 |