

PROTOCOL CODE: GIAVPEM

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: <input type="checkbox"/> 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)								
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="padding: 2px;">Drug</th> <th style="padding: 2px;">Dose Band (mg)</th> <th style="padding: 2px;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">pembrolizumab</td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></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 three weeks for Doctor and Cycle _____								
<input type="checkbox"/> Return in six weeks for Doctor and Cycles _____ and _____. Book treatment x 2 cycles.								
<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"/> creatine 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 (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