

**PROTOCOL CODE: GOENDAVPL**

<b>DOCTOR'S ORDERS</b>		Wt _____ kg						
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form								
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>						
<b>Date of Previous Cycle:</b>								
<input type="checkbox"/> Delay treatment _____ week(s)								
May proceed with pembrolizumab as written if within 96 hours <b>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.</b>								
May proceed with lenvatinib as written if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 75 x 10<sup>9</sup>/L, BP less than 160/100 mmHg, creatinine clearance greater than or equal to 30 mL/min, alkaline phosphatase or ALT less than or equal to 5 times the upper limit of normal, total bilirubin less than or equal to 3 times the upper limit of normal, urine protein less than 1 g/24 h</b>								
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Hypertension <input type="checkbox"/> Diarrhea <input type="checkbox"/> QTc prolongation <input type="checkbox"/> Other Toxicity								
Proceed with treatment based on blood work from _____								
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.								
Antiemetics per protocol								
For prior infusion reaction to pembrolizumab:								
<input type="checkbox"/> <b>diphenhydrAMINE 50 mg</b> PO 30 minutes prior to pembrolizumab								
<input type="checkbox"/> <b>acetaminophen 325 to 975 mg</b> PO 30 minutes prior to pembrolizumab								
<input type="checkbox"/> <b>hydrocortisone 25 mg</b> IV 30 minutes prior to pembrolizumab								
<b>TREATMENT:</b>								
<b>pembrolizumab 2 mg/kg x _____ kg = _____ mg (maximum 200 mg)</b>								
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter								
<b>Pharmacist to select dose band per last page of PPO. Complete table below (please print)</b>								
<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								
<b>lenvatinib (select one)</b> <input type="checkbox"/> <b>20 mg</b> PO once daily <input type="checkbox"/> <b>14 mg</b> PO once daily <input type="checkbox"/> <b>10 mg</b> PO once daily <input type="checkbox"/> <b>8 mg</b> PO once daily <input type="checkbox"/> <b>4 mg</b> PO once daily								
<b>Dispense:</b> 25 days or _____ days. <b>Order in increments of 5 days (only available as 5-day supply unit)</b>								
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>						
		<b>UC:</b>						

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<b>Date:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Please book Nurse for BP monitoring every 2 weeks x _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)	
<p><b>CBC &amp; Diff, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, magnesium, calcium, albumin, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle</b></p> <p><b>Every two weeks for first 2 months: ALT, alkaline phosphatase, total bilirubin, albumin</b></p> <p>During cycle 1 and 2: weekly telephone nursing assessment</p> <input type="checkbox"/> Cycle 3 onward: weekly telephone nursing assessment for _____ weeks <p>If clinically indicated:</p> <input type="checkbox"/> <b>24 hour urine protein within 3 days prior to next cycle for laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+</b> <input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>chest x-ray</b> <input type="checkbox"/> <b>MUGA scan or</b> <input type="checkbox"/> <b>echocardiogram</b> <input type="checkbox"/> <b>serum HCG or</b> <input type="checkbox"/> <b>urine HCG</b> – required for woman of childbearing potential <input type="checkbox"/> <b>free T3 and free T4</b> <input type="checkbox"/> <b>lipase</b> <input type="checkbox"/> <b>morning serum cortisol</b> <input type="checkbox"/> <b>random glucose</b> <input type="checkbox"/> <b>creatin kinase</b> <input type="checkbox"/> <b>serum ACTH levels</b> <input type="checkbox"/> <b>testosterone</b> <input type="checkbox"/> <b>estradiol</b> <input type="checkbox"/> <b>FSH</b> <input type="checkbox"/> <b>LH</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>total protein</b> <input type="checkbox"/> <b>phosphorus</b> <input type="checkbox"/> <b>C-reactive protein</b> <input type="checkbox"/> <b>troponin</b> <input type="checkbox"/> <b>INR</b> <input type="checkbox"/> <b>CA 125</b> <input type="checkbox"/> <b>CA 19-9</b> <input type="checkbox"/> <b>CA 15-3</b> <input type="checkbox"/> <b>CEA</b> <input type="checkbox"/> <b>Weekly nursing assessment for (specify concern):</b> _____  <input type="checkbox"/> <b>Other consults:</b>  <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>

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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