

PROTOCOL CODE: UGOENDAVP

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

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 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:		
<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)		
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		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____		
<input type="checkbox"/> Return in six weeks for Doctor and Cycles _____ and _____. Book chemo x 2 cycles.		
<input type="checkbox"/> Last cycle. Return in _____ week(s)		
CBC & Diff, creatinine, alkaline phosphatase, 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"/> free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol <input type="checkbox"/> random glucose		
<input type="checkbox"/> troponin <input type="checkbox"/> creatinine kinase <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"/> CA 19-9 <input type="checkbox"/> CA125 <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CEA		
<input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG – required for woman of childbearing potential		
<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