



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: HNAJPMBPRT
(Cycle 4 onward)

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)

May proceed with pembrolizumab 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 baseline**

Proceed with treatment based on blood work from _____

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

For prior pembrolizumab infusion reaction:

- diphenhydRAMINE 50 mg** PO 30 minutes prior to treatment
- acetaminophen 325 to 975 mg** PO 30 minutes prior to treatment
- hydrocortisone 25 mg** IV 30 minutes prior to treatment

TREATMENT:

pembrolizumab 2 mg/kg x _____ kg = _____ mg (max. 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)

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

OR

pembrolizumab 4 mg/kg x _____ kg = _____ mg (max. 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)

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle _____.
- Return in **six** weeks for Doctor and Cycle _____.
- Last Cycle. Return in _____ weeks.

CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH prior to each treatment

- If clinically indicated: **ECG** **chest X-ray**
- serum HCG** or **urine HCG** – required for woman of childbearing potential
 - free T3 and free T4** **lipase** **morning serum cortisol** **random glucose**
 - serum ACTH levels** **testosterone** **estradiol** **FSH** **LH**
 - weekly nursing assessment** for (specify concern): _____
 - Other: _____ Consults: _____
 - 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

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