PROTOCOL CODE: HNAJPMBPRT

(Inpatient Long Hydration - Cycles 1 and 2)

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

May proceed with CISplatin as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L, creatinine clearance greater than or equal to 60 mL/minute.**

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**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

INPATIENT TREATMENT

- Admit to inpatient bed
- Refer to inpatient ward policies and procedures for additional orders (e.g., bowel regimen, VTE prophylaxis, etc.)

ON ADMISSION:

- CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, calcium, albumin, magnesium, TSH

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

dexamethasone 12 mg PO/IV 30 to 60 minutes prior to CISplatin and then 4 mg PO/IV q12h x 6 doses
aprepitant 125 mg PO 30 to 60 minutes prior to CISplatin and 80 mg PO daily on Days 2 and 3
ondansetron 8 mg PO 30 to 60 minutes prior to CISplatin and then 8 mg PO/IV q12h x 6 doses

If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CISplatin
☐ **Other:**

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

SUPPORTIVE CARE MEDICATIONS:

☐ **LORazepam** 1 mg SL q4-6h PRN nausea, sleep or restlessness
☐ **prochlorperazine** 10 mg PO q6h PRN nausea
☐ **diphenhydrAMINE** 25-50 mg PO/IV q4-6h PRN
☐ **Other:**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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DATE:

CISplatin is only to be administered if concurrent with radiation

TREATMENT:

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

Hydration prior to CISplatin:
D5W-1/2 NS 1000 mL with potassium chloride 20mmol +plus magnesium sulfate 2 g IV over 3 hours.

Prior to beginning CISplatin, urine output must be greater than or equal to 300 mL in 3 hours. May repeat prehydration x 1000 mL to ensure urine output greater than 300 mL in 3 hours. If urine output not adequate after 2000 mL, notify physician.

When urine output is adequate, give:

CISplatin 100 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in NS 1000 mL with mannitol 30 g and potassium chloride 10 mmol over 2 hours.

Hydration post-CISplatin:
D5W-1/2 NS with potassium chloride 20 mmol/L + magnesium sulfate 2 g/L IV at 200 mL/h for 12 hours.

Measure intake and output every 3 hours while on IV. If output less than 300 mL during a 3-hour period, increase IV to 300 mL/hour for 3 hours. If urine output still less than 300 mL in a subsequent 3-hour period, give **furosemide** 20 mg IV x 1. If output still not adequate, notify physician. May discontinue IV and discharge after post hydration if urine output adequate and patient not vomiting.

DOCTOR'S SIGNATURE:

SIGNATURE:
UC:

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(Inpatient Long Hydration - Cycles 1 and 2)

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____. Admit for Day 1. ☐ Return in **three** weeks for Doctor and Cycle _____. Book outpatient treatment on Day 1.	
Prior to next treatment: **CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, calcium, albumin, magnesium, TSH** 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:**

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**