BC CANCER
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
(Pembrolizumab only – Cycle 3)

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:

☐ Delay treatment ______ week(s)

May proceed with pembrolizumab as written if within 96 hours **ALT <u>less than or equal to</u> 3 times the upper limit of normal, total bilirubin <u>less than or equal to</u> 1.5 times the upper limit of normal, creatinine <u>less than or equal to</u> 1.5 times the upper limit of normal and <u>less than or equal to</u> 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)**
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 <u>**three**</u> weeks for Doctor and Cycle 4.

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:

PEMBROLIZUMAB DOSE BANDING TABLE <u>(2 mg/kg capped 200 mg)</u>

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**