

PROTOCOL CODE: LUNAPGPMB

Adjuvant Phase

(Page 1 of 3)

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)
 CBC & Diff day of treatment

May proceed with treatment if within 96 hours 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, 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

Dose modification for: Hematology Other Toxicity: _____

Proceed with treatment based on blood work from _____

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

For prior 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
 Other:

****Have Hypersensitivity Reaction Tray & Protocol Available****

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		

OR

pembrolizumab 4 mg/kg x _____ kg = _____ mg (**max. 400 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		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

PROTOCOL CODE: LUNAPGPMB**Adjuvant Phase**

(Page 2 of 3)

DATE:		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in <u>three</u> weeks for Doctor and Cycle _____.		
<input type="checkbox"/> Return in <u>six</u> week(s) and Cycle _____.		
<input type="checkbox"/> Last cycle. Return in _____ weeks.		
CBC & Diff, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, TSH, random glucose prior to each treatment		
If clinically indicated:		
<input type="checkbox"/> ECG <input type="checkbox"/> chest x-ray		
<input type="checkbox"/> serum HCG or <input type="checkbox"/> urine HCG (select one) – required for woman of childbearing potential		
<input type="checkbox"/> free T3 and free T4 <input type="checkbox"/> lipase <input type="checkbox"/> morning serum cortisol		
<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"/> Weekly nursing assessment for (specify concern): _____		
<input type="checkbox"/> Consults:		
<input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:	SIGNATURE:	
UC:		

PROTOCOL CODE: LUNAPGPMB

Adjuvant Phase

(Page 3 of 3)

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
265.5	284.49	275
285.5	332.49	300
333.5	374.49	350
374.5	400	400