

PROTOCOL CODE: LUNAPGPMB

Neoadjuvant Phase

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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:		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment		
May proceed with gemcitabine, CISplatin CARBOplatin as written if within 48 hours ANC <u>greater than or equal to 1.0 x 10⁹/L</u> , platelets <u>greater than or equal to 100 x 10⁹/L</u> , creatinine clearance <u>greater than or equal to 60 mL/minute</u> (if using CISplatin)		
May proceed with pembrolizumab if within 96 hours <u>creatinine less than or equal to 1.5 times the upper limit of normal</u> and <u>less than or equal to 1.5 times the baseline</u> , ALT <u>less than or equal to 3 times the upper limit of normal</u> , total bilirubin <u>less than or equal to 1.5 times the upper limit of normal</u>		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity: _____		
Proceed with treatment based on blood work from _____		
PREMEDIcATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.		
dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment on Day 1		
AND select ONE of the following:	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to treatment on Day 1, and ondansetron 8 mg PO 30 to 60 minutes prior to treatment on Day 1
	<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment on Day 1
	<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to treatment on Day 1
If additional antiemetic required: <input type="checkbox"/> OLANZapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to treatment on Day 1		
For prior infusion reaction to pembrolizumab: <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 <input type="checkbox"/> Other:		
Have Hypersensitivity Reaction Tray & Protocol Available		
HYDRATION: 1000 mL NS over 1 hour prior to CISplatin		
Continued on page 2		
DOCTOR'S SIGNATURE:		SIGNATURE: UC:

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DATE:

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 **Day 1**

Pharmacist to select dose band per last page of PPO. Complete table below (please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

gemcitabine 1000 mg/m² x BSA = _____ mg

Dose Modification: (_____ %) = _____ mg/m² x BSA = _____ mg

IV in 250 mL NS over 30 minutes on **Day 1 and Day 8**

CISplatin 75 mg/m²/day x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 500 mL NS, with potassium chloride 20 mEq, magnesium sulfate 1 g and mannitol 30 g over 1 hour **Day 1**

OR

CARBOplatin AUC 5 x (GFR + 25) = _____ mg IV in 100 to 250 mL NS over 30 minutes **Day 1**

DOSE MODIFICATION FOR DAY 8

gemcitabine 1000 mg/m² x BSA = _____ mg

Dose Modification: (_____ %) = _____ mg/m² x BSA = _____ mg

IV in 250 mL NS over 30 minutes

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____. Book chemo Day 1 and 8.

Return in _____ week(s) for post-operative visit and Cycle 5 (adjuvant phase). Book chemo Day 1.

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

CBC & Diff, creatinine prior to Day 8

If clinically indicated: ECG chest X-ray

serum HCG or urine HCG – required for woman of child bearing potential

Free T3 and free T4 lipase morning serum cortisol serum ACTH levels

random glucose testosterone estradiol FSH LH creatine kinase

Weekly nursing assessment

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