PROTOCOL CODE: LUNAPPPMB
Adjuvant Phase

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)
☐ **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: LUNAPPPMB
Adjuvant Phase

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____. ☐ Return in **six** week(s) 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** (select one) – required for woman of childbearing potential ☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **creatine kinase** ☐ **random glucose** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **Weekly nursing assessment for (specify concern): _____** ☐ **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**

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**