PROTOCOL CODE: LUNAPPPMB
Neoadjuvant 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 pemetrexed, CISplatin, CARBOplatin 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, and creatinine clearance greater than or equal to 45 mL/minute (**for pemetrexed and CARBOplatin**),** or **greater than or equal to 60 mL/minute** (for CISplatin)

May proceed with pembrolizumab 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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment

AND select **ONE** of the following:	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment, and **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment
	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment

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

Ensure patient is taking **folic acid** and has had **vitamin B12** injection starting at least 7 days prior to first cycle, and to continue while on treatment, until 21 days after last pemetrexed dose.

For prior infusion reaction to pembrolizumab:
☐ **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****

PREHYDRATION:

1000 mL NS over 60 minutes prior to CISplatin

Continued on page 2

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

PROTOCOL CODE: LUNAPPPMB
Neoadjuvant Phase

DATE:

****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 (may be given during prehydration)

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

Drug	Dose Band (mg)	Pharmacist Initial and Date
pembrolizumab		

pemetrexed 500 mg/m² x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 100 mL NS over 10 minutes (may be given during prehydration)

Select one:
☐ **CISplatin 75 mg/m²** x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 500 mL NS, with potassium chloride 20 mmol, magnesium sulphate 1 g and mannitol 30 g over 60 minutes

OR

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

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____.
☐ Return in _____ week(s) for post-operative visit and Cycle 5 (adjuvant phase).

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** ☐ **serum ACTH levels**
☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **creatine kinase** ☐ **random glucose**
☐ **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**