PROTOCOL CODE: SMAVPEM

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DOCTOR'S ORDERS   Wt_____kg

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:**   **Cycle #(s) _____**

Date of Previous Cycle:

☐ Delay treatment _____ week(s). Dose delay for: _____
May proceed with doses as written if within 96 hours **ALT <u>less than or equal to</u> 3 times the upper limit of normal and <u>bilirubin less than or equal</u> to 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 X baseline.

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 mg to 975 mg** PO 30 minutes prior to treatment
   ☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment   ☐ **Other:**_____

TREATMENT: ☐ Repeat in three weeks
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.

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle # _____

☐ Return in six weeks for Doctor and Cycle #s _____ and _____. Book for 2 cycles.

☐ Last cycle. Return in _____ week(s)

CBC and diff, platelets, 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 child bearing potential
☐ **Free T4 and free T3** ☐ **lipase** ☐ **morning serum cortisol** ☐ **serum ACTH levels**
☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **glucose**
☐ **Weekly nursing assessment**

☐ **Other consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC: