BC CANCER
Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAVPEM6

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:

Indicate the number of pembrolizumab doses patient has received together with chemotherapy (not as single agent) to date: __________________

☐ Delay treatment ______ week(s)

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, total bilirubin <u>less than or equal to</u> 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 times the 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 to 975 mg** PO 30 minutes prior to treatment

☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment

TREATMENT:

pembrolizumab 4 mg/kg x ______ kg = _________ mg **(max. 400 mg) every 6 weeks**

IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

RETURN APPOINTMENT ORDERS

☐ Return in **<u>six</u>** <u>weeks</u> for Doctor and Cycle______

☐ Last cycle. Return in ______ week(s)

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

If clinically indicated: ☐ **morning serum cortisol** ☐ **creatine kinase** ☐ **lipase**

☐ **GGT** ☐ **LDH** ☐ **random glucose** ☐ **free T3 and free T4**

☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**

☐ **CA15-3** ☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential

☐ **ECG** ☐ **chest x-ray**

☐ **Weekly nursing assessment**

☐ **Other consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: