PROTOCOL CODE: GUAVPEML6

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)

May proceed with pembrolizumab as written if within 96 hours **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**,** creatinine **less than or equal to** 1.5 times the upper limit of normal *and* **less than or equal to** 1.5 X baseline.

May proceed with lenvatinib as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L**, **platelets greater than or equal to 75 x 10^9/L**, **BP less than 160/100 mmHg, creatinine clearance greater than or equal to 30 mL/min**, **alkaline phosphatase or ALT less than or equal to 5 X ULN**, **total bilirubin less than or equal to 3 X ULN**, **urine protein less than 1 g/24 h**

Dose modification for:
☐ **Hematology** ☐ **Hypertension** ☐ **Diarrhea** ☐ **QTc prolongation** ☐ **Other Toxicity**
Proceed with treatment based on blood work from _____

PREMEDICATIONS:

Patient to take own supply. RN/Pharmacist to confirm _____.

Antiemetics per protocol

For prior infusion reaction to pembrolizumab:
☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to pembrolizumab
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to pembrolizumab
☐ **hydrocortisone 25 mg** IV 30 minutes prior to pembrolizumab

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

lenvatinib (select one)
☐ **20 mg** PO once daily
☐ **14 mg** PO once daily
☐ **10 mg** PO once daily
☐ **8 mg** PO once daily
☐ **4 mg** PO once daily

Mitte: 45 days or _____ days. **Order in increments of 5 days (only available as 5-day supply unit)**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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Date:

RETURN APPOINTMENT ORDERS

☐ Return in **six** weeks for Doctor and Cycle_____
☐ Please book Nurse for BP monitoring q 2 weeks x _____
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, platelets, creatinine, ALT, alkaline phosphatase, total bilirubin, sodium, potassium, magnesium, calcium, albumin, TSH, dipstick or laboratory urinalysis for protein, blood pressure measurement prior to each cycle

Every two weeks for first 2 months: ALT, alkaline phosphatase, total bilirubin, albumin

During cycle 1: weekly telephone nursing assessment
☐ Cycle 2 onward: every _____ weeks telephone nursing assessment for _____ weeks

If clinically indicated:

☐ **24 hour urine protein within 3 days prior to next cycle for laboratory urinalysis for protein greater than or equal to 1g/L or dipstick proteinuria 2+ or 3+**
☐ **ECG** ☐ **Chest X-ray** ☐ **MUGA scan or** ☐ **echocardiogram**
☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential
☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol**
☐ **random glucose** ☐ **creatine kinase** ☐ **serum ACTH levels**
☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **GGT**
☐ **total protein** ☐ **phosphorus** ☐ **C-reactive protein** ☐ **troponin** ☐ **INR**

☐ **Other consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: