MIC METRO INFUSION CENTER

Pembrolizumab (Keytruda)

Name: _____
DOB: _____
Diagnosis/Code: _____/_____

Weight: _____kg

☐ Call for weight change greater than 10 % from baseline
☐ No dose modifications required for any weight change

BSA: N/A:

Mg/Kg dosing

Laboratory or Other Tests Related to Treatment:
CMP with each treatment
☐ CBC with each treatment
Other: _____;
Patient should have a TSH; at least every 3 cycles (call if these labs have not been ordered after 3 cycles)

Dosing Guidelines/ Parameters: **Provider must select hold parameters that will trigger a call from the RN**
☐ No hold for ANC/Plt
☐ Hold and call provider for ANC: _____/Platelet: _____
☐ Hold and call for LFT's 3 x ULN and/or Bilirubin 1.5x ULN
☐ Hold and call for creatinine 1.5x ULN
☐ No hold parameters

Hydration Orders: ☐ Not Required

Premedication and Antiemetic Orders: ☐ Not Required (minimal emetogenic potential)

Treatment Orders:

DRUG	DOSE CALCULATION	DOSE	SOLUTION AND VOLUME	ROUTE	RATE	FREQUENCY, DATES TO BE GIVE AND TOTAL DOSES
☐ Pembrolizumab (Keytruda)	2mg/kg	_____mg	As per pharmacy	IVPB	30 min	Every 3 weeks
☐ Pembrolizumab (Keytruda)	Flat Dose	200mg	As per pharmacy	IVPB	30 min	Every 3 weeks
☐ Pembrolizumab (Keytruda)	Flat Dose	400mg	As per pharmacy	IVPB	30 min	Every 42 days

Date of first treatment:_____/subsequent treatments may be given +/- 2 days

This order is good for 1 year from the date ordered

Other:
Use inline non-pyrogenic, low protein binding in-line filter (pore size of 0.2-0.5 micron)

Oral cancer treatment patient is on: _____

Call referring provider for:

1. Rash
2. Diarrhea of 6/day
3. Elevated LFT's or creatinine as outlined above
4. Severe SOB; pulse oximeter less than 90%
5. Severe fatigue or weight loss
6. Neurologic changes
7. Allergic reaction- will plan for premeds with subsequent cycles

Other reasons to call:

DATE

Referring Provider:_____ _____ **Telephone**_____
SIGNATURE REQUIRED PRINTED NAME REQUIRED