

Doctor's Order Sheet
pembrolizumab 4 mg/kg Regimen
ARIA Protocol Name: Pembrolizumab
 UROTHELIAL 4 mg/kg
 Adult Chemotherapy - Medical Oncology
 Urothelial Carcinoma

Name _____
 HCN _____
 Date of _____



CC3430 0154 02 2021

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

Allergies: No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
 Cycle: _____ of _____ **Cycle Duration: 42 days** Date of previous cycle: DD/MONTH/YYYY

- MAY PROCEED WITH DOSES AS WRITTEN IF:**
- CBC and differential assessed.
 - LFTs and Bilirubin assessed.
 - Creatinine clearance assessed.
 - Thyroid function assessed.

PREMEDICATIONS: None recommended
 Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):
 pembrolizumab 4 mg/kg X Weight (kg) = _____ mg (maximum dose 400mg)
 IV in 50 mL normal saline over 30 minutes on day 1

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.