CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

pembrolizumab 2 mg/kg - aXitinib 10 mg Regimen

ARIA Protocol Name: Pembrolizumab 2 mg/kg / Axitinib 10 mg PO bid

Adult Chemotherapy - Medical Oncology
Metastatic Renal Cell Carcinoma

CC3490 0160 06 2021

Name:

HCN:

Date of Birth:

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: 21 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Blood pressure assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.
- Proteinuria assessed.
- Toxicities recovered to less than or equal to grade 2

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **aXitinib 10 mg PO** bid

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X Weight (kg) = _____ **mg (maximum dose 200 mg)**
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.