

Name: _____

HCN: _____

Date of Birth: _____

Doctor's Order Sheet

pembrolizumab 2 mg/kg Regimen

ARIA Protocol Name: pembrolizumab 2 mg/kg - mCRC

Adult Chemotherapy - Medical Oncology

dMMR/MIS-H Metastatic Colorectal Cancer Therapy



CC3910 0202 05 2022

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:

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

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

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.