



Cancer Care Program

Doctor's Order Sheet

**pembrolizumab 200 mg -
lenvatinib 20 mg Regimen: (Part I)**

ARIA Protocol Name: pembrolizumab 200 mg lenvatinib 20 mg - Compassionate
Adult Chemotherapy – Gynecologic Oncology
Advanced Endometrial Carcinoma Therapy



CC4750 0285 02 2023

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

Name: _____

HCN: _____

Date of Birth: _____

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** $1.0 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.
- Blood pressure assessed.

PREMEDICATIONS:

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

lenvatinib 20 mg

Dose modification: **lenvatinib 14 mg**

Dose modification: **lenvatinib 10 mg**

Dose modification: **lenvatinib ____ mg**

PO once daily on days 1 to 21 (lenvatinib to be prescribed in 30 day lots as per available manufacturer packaging)

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.

**pembrolizumab 200 mg -
lenvatinib 20 mg Regimen: (Part II)**

ARIA Protocol Name: pembrolizumab 200 mg lenvatinib 20 mg - Compassionate
Adult Chemotherapy – Gynecologic Oncology
Advanced Endometrial Carcinoma Therapy



CC4750 0285 02 2023

Name: _____

HCN: _____

Date of _____

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

pembrolizumab 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: _____

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