CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 400 mg - lenvatinib 20 mg Regimen: (Part I)

ARIA Protocol Name: pembrolizumab 400 mg lenvatinib 20 mg - Compassionate

Adult Chemotherapy – Gynecologic Oncology

Advanced Endometrial Carcinoma Therapy

CC4760 0286 02 2023

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:

- ANC **greater than or equal to** 1.0 X 10^9/L and platelets **greater than or equal to** 75 X 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 42 (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.

CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of

Doctor's Order Sheet

pembrolizumab 400 mg - lenvatinib 20 mg Regimen: (Part II)

ARIA Protocol Name: pembrolizumab 400 mg lenvatinib 20 mg - Compassionate

Adult Chemotherapy – Gynecologic Oncology

Advanced Endometrial Carcinoma Therapy

CC4760 0286 02 2023

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 400 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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