CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 2 mg/kg - PACLitaxel 175 - CARBOplatin AUC 5 - Zirabev® (bevacizumab) 15 mg/kg

Regimen: (Part I) Cycle 7 +

ARIA Protocol Name: pembrolizumab2 PACLitaxel175 CARBOplatin AUC5 bevacizumab15

Adult Chemotherapy - Gynecologic Oncology

Persistent, Recurrent or Metastatic Cervical Cancer Treatment

CC5370 0347 06 2023

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 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.
- Blood pressure assessed.
- Dipstick urine or laboratory urinalysis for protein assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ Other: _____

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.

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Doctor's Order Sheet

pembrolizumab 2 mg/kg - PACLitaxel 175 - CARBOplatin AUC 5 - Zirabev® (bevacizumab) 15 mg/kg

Name:

HCN:

Date of Birth:

Regimen: (Part II) Cycles 7 +

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

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

☐ **Zirabev® (bevacizumab) 15 mg/kg** X Weight (kg) **= _____ mg**

☐ Dose modification: **Zirabev® (bevacizumab) 15 mg/kg** X weight (kg) - _____% = _____ **mg**

IV in 100 to 250 mL normal saline on day 1 over:

- **60** minutes during **Cycle 1**;
- If tolerated without reaction - **30** minutes during **Cycle 2** and all other cycles

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: _____