

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor's Order Sheet

**pembrolizumab 4 mg/kg Regimen**

**ARIA Protocol Name:** pembrolizumab 4 mg/kg Endometrial

Adult Chemotherapy - Gynecologic Oncology

Endometrial Cancer Therapy



CC5490 0359 05 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:**

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

**PREMEDICATIONS:** None recommended

Other: \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**pembrolizumab 4 mg/kg X Weight (kg) = \_\_\_\_\_ mg (maximum dose 400mg)**

**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.