CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 4 mg/kg Regimen

ARIA Protocol Name: Pembrolizumab 4 mg/kg – Adjuvant Melanoma

Adult Chemotherapy - Medical Oncology

Adjuvant Melanoma Therapy

CC5170 0327 11 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.