

**pembrolizumab 4 mg/kg -
lenvatinib 20 mg Regimen: (Part I)**

ARIA Protocol Name: pembrolizumab 4 mg/kg lenvatinib 20 mg - Endometrial Adult Chemotherapy – Gynecologic Oncology Advanced Endometrial Carcinoma Therapy



CC5560 0366 11 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: 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 10⁹/L and platelets **greater than or equal to** 75 X 10⁹/L, otherwise notify Gynecological Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Blood pressure assessed.

PREMEDICATIONS:

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- lenvatinib 20 mg PO** once daily for 60 days
- Dose modification: **lenvatinib 14 mg PO** once daily for 60 days
 - Dose modification: **lenvatinib 10 mg PO** once daily for 60 days
 - Dose modification: **lenvatinib 8 mg PO** once daily for 60 days
 - Dose modification: **lenvatinib 4 mg PO** once daily for 60 days
- To be dispensed in lots of 30 days 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: _____

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**pembrolizumab 4 mg/kg -
lenvatinib 20 mg Regimen: (Part II)**

ARIA Protocol Name: pembrolizumab 4 mg/kg lenvatinib 20 mg - Endometrial
Adult Chemotherapy – Gynecologic Oncology
Advanced Endometrial Carcinoma Therapy



CC5560 0366 11 2023

Name: _____

HCN: _____

Date of Birth: _____

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

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: _____

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