CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

pembrolizumab 2 mg/kg - Abraxane® (nab-PACLitaxel) 100 Regimen

Name:

HCN:

Date of Birth:

ARIA Protocol Name: pembrolizumab 2 mg/kg nab-PACLitaxel 100
Adult Chemotherapy - Medical Oncology
Metastatic Triple Negative Breast Cancer

CC6400 0450 02 2024

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: 21 days** Date of previous cycle: DD/MONTH/YYYY ________

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ Other: ________________________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X Weight (kg) = ___________ **mg (maximum dose 200 mg)**

IV in 50 mL normal saline over 30 minutes on day 1

☐ **Abraxane® (nab-PACLitaxel) 100 mg/m²** X BSA =___________**mg**

☐ Dose modification: **Abraxane® (nab-PACLitaxel) 100 mg/m²** X BSA - _________% = ___________ **mg**

IV in Viaflex bag over 30 minutes on days 1 and 8

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.