CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 400 mg Regimen

ARIA Protocol Name: pembrolizumab 400 mg - Compassionate - Keynote-091

Adult Chemotherapy - Medical Oncology

Adjuvant Stage IB - IIIA Non-Small Cell Lung Cancer (NSCLC) Therapy

CC6830 0503 09/2024

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: 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 400 mg**

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

This regimen is NOT funded by the Cancer Care Program. Approved only for patients enrolled in the compassionate access.

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.