CANCERCare
A PROGRAM OF EASTERN HEALTH

Name:

HCN:

Date of Birth:

Cancer Care Program

Doctor's Order Sheet

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

ARIA Protocol Name: pembrolizumab 4 mg/kg lenvatinib 20 mg - RCC

Adult Chemotherapy – Medical Oncology

Advanced Renal Cell Carcinoma

CC6090 0419 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:

- ANC **greater than or equal to** 1.0 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

CANCERCare
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Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

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

ARIA Protocol Name: pembrolizumab 4 mg/kg lenvatinib 20 mg - RCC

Adult Chemotherapy – Medical Oncology

Advanced Renal Cell Carcinoma

CC6090 0419 11 2023

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: _____