

Doctor's Order Sheet

**pembrolizumab 4 mg/kg**

Regimen

**ARIA Protocol Name:** pembrolizumab 4 mg/kg - Metastatic Breast Maintenance

Adult Chemotherapy - Medical Oncology

Metastatic Breast Cancer Therapy



CC6940 0514 10/2024

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:**

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance 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. Administer with 0.2 or 0.22 micron low protein binding in-line filter.

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.