CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

dostarlimab 1000 mg

Regimen

Name:

HCN:

Date of Birth:

ARIA Protocol Name: dostarlimab1000 maintenance – Endometrial

Adult Chemotherapy - Gynecologic Oncology

Primary Advanced or Recurrent dMMR/MSI-H Endometrial Cancer Treatment

CC7160 0536 02 2025

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):

☐ **dostarlimab 1000 mg**

IV in 100 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: _____