

**pembrolizumab 200 mg -
PACLitaxel 175 -**

CARBOplatin AUC 5 Regimen: (Part I) Cycles 1-6

ARIA Protocol Name: pembro200 Pac175 CarbAUC5 - Endometrial - Compassionate

Adult Chemotherapy - Gynecologic Oncology

Primary Advanced or Recurrent Endometrial Carcinoma



CC7220 0542 03 2025

Name: _____

HCN: _____

Date of Birth: _____

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** $1.0 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Gynecologic Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

45 minutes prior to PACLitaxel: dexamethasone 20 mg IV in 50 mL normal saline over 15 minutes on day 1

30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV in 50 mL normal saline over 15 minutes on day 1

Administer concurrently with famotidine via y-site.

30 minutes prior to PACLitaxel: famotidine 20 mg IV in 100 mL normal saline over 15 minutes on day 1

Administer concurrently with diphenhydrAMINE via y-site.

ondansetron 8 mg PO on day 1

Other: _____

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.

Doctor's Order Sheet

**pembrolizumab 200 mg -
PACLitaxel 175 -
CARBOplatin AUC 5**

Regimen: (Part II) Cycles 1-6

ARIA Protocol Name: pembro200 Pac175 CarbAUC5 - Endometrial - Compassionate

Adult Chemotherapy - Gynecologic Oncology

Primary Advanced or Recurrent Endometrial Carcinoma

Name: _____

HCN: _____

Date of Birth: _____



CC7220 0542 03 2025

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

pembrolizumab 200 mg IV in 50 mL normal saline over 30 minutes on day 1

PACLitaxel 175 mg/m² X BSA = _____ mg

Dose modification: **PACLitaxel 175 mg/m²** X BSA - _____ % = _____ mg

IV in 500 mL normal saline PVC Free over 180 minutes on day 1

CARBOplatin AUC 5 = _____ mg

Dose modification: **CARBOplatin AUC 5** - _____ % = _____ mg

IV in 250 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: _____

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