

Doctor's Order Sheet
pembrolizumab 400 mg
Regimen

Name: _____
HCN: _____
Date of Birth: _____

ARIA Protocol Name: pembro 400mg maintenance – Endometrial - Compassionate
Adult Chemotherapy - Gynecologic Oncology
Primary Advanced or Recurrent Endometrial Carcinoma



CC7230 0543 03 2025

Allergies:		<input type="checkbox"/> No Known
Date: <u>DD/MONTH/YYYY</u>	Cycle _____ of _____	Planned Administration Date: <u>DD/MONTH/YYYY</u> Date of previous cycle: <u>DD/MONTH/YYYY</u>
Cycle Duration: 42 days		
MAY PROCEED WITH DOSES AS WRITTEN IF:		
<ul style="list-style-type: none"> • CBC with differential assessed. • LFTs and Bilirubin assessed. • Creatinine clearance assessed. • Thyroid function assessed. 		
PREMEDICATIONS (FOR HOSPITAL PHARMACY):		
<input type="checkbox"/> Other: _____		
CHEMOTHERAPY (FOR HOSPITAL PHARMACY):		
<input type="checkbox"/> pembrolizumab 400 mg 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: _____

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