CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

pembrolizumab 2 mg/kg - DOCEtaxel 75 - CARBOplatin AUC 5 Regimen: Part I

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Pembro2mg/kg Doce75mg/m2 CarboAUC5

Adult Chemotherapy - Medical Oncology

Neoadjuvant Triple Negative Breast Cancer Therapy

CC7300 0550 04 2025

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** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 8 mg PO** bid for 3 days, starting one day prior to DOCEtaxel.

Patient must receive a minimum of three doses prior to receiving treatment.

☐ Other: _____

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **fosaprepitant 150 mg IV** in 150 mL normal saline over 30 minutes on day 1

☐ **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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 2 mg/kg - DOCEtaxel 75 - CARBOplatin AUC 5 Regimen: Part II

ARIA Protocol Name: Pembro2mg/kg Doce75mg/m2 CarboAUC5

Adult Chemotherapy - Medical Oncology

Neoadjuvant Triple Negative Breast Cancer Therapy

CC7300 0550 04 2025

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X Weight (kg) = _____ **mg (maximum dose 200 mg)**
IV in 50 mL normal saline over 30 minutes on day 1

☐ **DOCEtaxel 75 mg/m²** X BSA = _____ **mg**
☐ Dose modification: **DOCEtaxel 75 mg/m²** X BSA - _____% = _____ **mg**
IV in 250 mL normal saline PVC Free with 0.2 micron in-line filter over 60 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

POST-CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **filgrastim (Brand: _____) _____ mcg** subcutaneous daily for 7 days starting 24-48 hours post chemotherapy

☐ **peg-filgrastim (Brand:_____) 6 mg** subcutaneous for one dose 24-48 hours post chemotherapy

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.