

Doctor's Order Sheet

**enfortumab vedotin 1.25 mg/kg -
pembrolizumab 2 mg/kg**

Regimen (Part I)

ARIA Protocol Name: enfortumab vedotin pembrolizumab Funded

Adult Chemotherapy - Medical Oncology

First line Advanced Urothelial Cancer



CC7730 0593 09/2025

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

Name _____

HCN _____

Date of _____

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** $75 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Random glucose less than or equal to 13.9 mmol/L

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- metoclopramide 10 mg PO** pre enfortumab vedotin on days 1 and 8
- Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- enfortumab vedotin 1.25 mg/kg X Weight (kg) = _____ mg (maximum dose 125 mg)**
- Dose modification: **enfortumab vedotin 1 mg/kg X Weight (kg) = _____ mg (maximum dose 100 mg)**
- Dose modification: **enfortumab vedotin 0.75 mg/kg X Weight (kg) = _____ mg (maximum dose 75 mg)**
- Dose modification: **enfortumab vedotin 0.5 mg/kg X Weight (kg) = _____ mg (maximum dose 50 mg)**
- IV** in 50 mL normal saline over 30 minutes on days 1 and 8. Observe for 60 minutes post infusion for first 3 doses.

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: _____

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Doctor's Order Sheet

**enfortumab vedotin 1.25 mg/kg -
pembrolizumab 2 mg/kg**

Regimen (Part II)

ARIA Protocol Name: enfortumab vedotin pembrolizumab Funded

Adult Chemotherapy - Medical Oncology

First line Advanced Urothelial Cancer



CC7730 0593 09/2025

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

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: _____

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Name

HCN

Date of