

Doctor's Order Sheet
pembrolizumab 4 mg/kg -
aXitinib 5 mg Regimen
ARIA Protocol Name: pembrolizumab 4 mg/kg
 axitinib 5 mg - RCC
 Adult Chemotherapy - Medical Oncology
 Metastatic Renal Cell Carcinoma

Name: _____
 HCN: _____
 Date of Birth: _____



CC7940 0614 12 2025

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

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:

- ANC **greater than or equal to** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Blood pressure assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.
- Proteinuria assessed.
- Toxicities recovered to less than or equal to grade 2

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- aXitinib 5 mg PO** twice daily for 60 days
- Dose modification: **aXitinib 3 mg PO** twice daily for 60 days
 - Dose modification: **aXitinib 2 mg PO** twice daily for 60 days

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- pembrolizumab 4 mg/kg X Weight (kg) = _____ mg (maximum dose 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.