

Doctor's Order Sheet

**pembrolizumab 200/400 mg -
CISplatin 40**

Regimen: Cycles 3-5

ARIA Protocol Name: Cisp40Pembro200 (Keytruda) - Compassionate

Adult Chemotherapy - Gynecologic Oncology

Newly diagnosed, high-risk, locally advanced cervical cancer

Name: _____

HCN: _____

Date of Birth: _____



CC7960 0616 12 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:

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

pembrolizumab 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: _____

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