

Doctor's Order Sheet
**pembrolizumab 200/400 mg -
 CISplatin 40**
 Regimen: Cycles 6+

Name: _____
 HCN: _____
 Date of Birth: _____

ARIA Protocol Name: Pembro400maint (Keytruda) - Compassionate
 Adult Chemotherapy - Gynecologic Oncology
 Newly diagnosed, high-risk, locally advanced cervical cancer



CC7970 0617 12 2025

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

PREMEDICATIONS: None recommended
 Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):
 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.