CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

pembrolizumab 200/400 mg - CARBOplatin AUC 2

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

CC7990 0619 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.