

**CISplatin – Trastuzumab –  
Capecitabine Regimen:  
(Part I)**  
Adult Chemotherapy- Medical Oncology  
**Metastatic, Locally Advanced Gastric or  
Gastroesophageal Junction Adenocarcinoma Therapy**



CC1360 0007 06 2017

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**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**  $1.5 \times 10^9/L$ , platelets **greater than or equal to**  $100 \times 10^9/L$ , Creatinine Clearance **greater than or equal to** 60 mL/minute, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

**PREMEDICATIONS:**

- ☐ Fosaprepitant 150 mg IV in 150 mLs Normal Saline over 30 minutes on Day 1
- ☐ Dexamethasone 12 mg PO
- ☐ Ondansetron 16 mg PO
- ☐ Other: \_\_\_\_\_

**HYDRATION/SUPPORTIVE CARE**

- ☐ Normal Saline 1000 mLs IV pre-CISplatin over 120 minutes on Day 1

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. USER WILL BE SOLELY RESPONSIBLE FOR VERIFYING ITS CURRENCY AND ACCURACY.

**CISplatin – Trastuzumab –  
Capecitabine Regimen:**

(Part II)

Adult Chemotherapy- Medical Oncology

**Metastatic, Locally Advanced Gastric or  
Gastroesophageal Junction Adenocarcinoma Therapy**



CC1360 0007 06 2017

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY)**

☐ **CISplatin 80 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg + mannitol 25 grams IV** in 500 mLs NS

infused at 1 mg/min on Day 1

☐ **Dose modification: 80 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg + mannitol 25 grams IV**

in 500 mLs NS infused at 1 mg/min on Day 1

**CYCLE 1 ONLY:**

☐ **Trastuzumab (Herceptin®) 8 mg/kg X weight (kg) = \_\_\_\_\_ mg IV** in 250 mLs NS over 90 minutes on Day 1

**POST CYCLE 1:**

☐ **Trastuzumab (Herceptin®) 6 mg/kg X weight (kg) = \_\_\_\_\_ mg IV** in 250 mLs NS

over 60 minutes on Day 1 (Cycle 3 and beyond can be administered over 30 minutes)

**HYDRATION/SUPPORTIVE CARE**

☐ **Normal Saline 1000 mLs IV with Magnesium Sulfate 2 grams & Potassium Chloride 20 mEq**

post-chemotherapy over 120 minutes on Day 1

**CHEMOTHERAPY (FOR COMMUNITY PHARMACY)**

☐ **Capecitabine 1000 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg PO bid** with food on Days 1 to 14

☐ **Dose modification: 1000 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg PO bid** with food on Days 1 to 14

This prescription is NOT eligible for medication management by a pharmacist.

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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