CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet
ramucirumab **8** Regimen:
ramucirumab
Adult Chemotherapy- Medical Oncology
Metastatic, Locally Advanced Gastric or Gastroesophageal Junction Adenocarcinoma

CC1590 0030 06 2017

Name

HCN

Date of

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

Allergies: ☐ **No Known**

Date: ___DD/MONTH/YYYY_____ Planned Administration Date (Day 1): ___DD/MONTH/YYYY_____
Cycle_____ of _____ **Cycle Duration: 28 days** Date of previous cycle: _____DD/MONTH/YYYY_____

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFT's, Bilirubin and Blood Pressure assessed
- Creatinine clearance assessed
- Thyroid function assessed every 2 to 3 cycles
- Proteinuria-Urinalysis: Assess baseline and before each cycle. If urine protein level is 2+ or higher, perform 24-hour urine collection. If this is abnormal, dose reductions are required.

PREMEDICATIONS:

☐ **diphenhydrAMINE 50 mg IV pre ramucirumab x 1 dose on Days 1 and 15**

☐ **dexamethasone 20 mg IV pre ramucirumab, if prior grade 1 or 2 infusion reaction to ramucirumab**

☐ **acetaminophen 500mg PO pre ramucirumab, if prior grade 1 or 2 infusion reaction to ramucirumab**

☐ **Other:** _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **ramucirumab 8 mg/kg= _____**mg IV in 250 mL normal saline (total volume)
over 60 minutes on days 1 and 15 (Use 0.22 micron in-line filter)

☐ Dose modification: **8 mg/kg** - _____% = _____ mg IV in 250 mLs normal saline (total volume)
over 60 minutes on days 1 and 15

Authorized Prescriber: _____ Date: _____DD/MONTH/YYYY____Time: _____

Authorized Prescriber's Signature: _____ ID Number: _____

Nurse's Name: _____ Date: _____DD/MONTH/YYYY_____ Time: _____

Nurse's Signature: _____