

Name: _____

HCN: _____

Date of Birth: _____



CC1390 0010 062018

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** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, Creatinine Clearance **greater than** 50 mL/minute, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

PREMEDICATIONS:

- Ondansetron 16 mg PO
- Dexamethasone 8 mg PO
- Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- Irinotecan $200 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg IV in 500 mL D5W over 90 minutes on Day 1
- Dose modification: $200 \text{ mg/m}^2 \times \text{BSA} -$ _____ % = _____ mg IV in 500 mL D5W over 90 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.

Doctor's Order Sheet
CAPIRI Regimen:
Irinotecan - Capecitabine
(Part II)
Adult Chemotherapy- Medical Oncology
Metastatic Colorectal Carcinoma

Name: _____

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

CHEMOTHERAPY (FOR COMMUNITY PHARMACY)

Capecitabine 800 mg/m² X BSA = _____ mg PO bid with food on Days 1 to 14

Dose modification: **800 mg/m²** X BSA - _____ % = _____ mg PO bid with food on Days 1 to 14

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

HYDRATION/SUPPORTIVE CARE

Atropine 0.4 mg intravenous prn for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis, or flushing.

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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