

Doctor's Order Sheet

CABAZItaxel 25 Regimen

ARIA Protocol Name: CABAZItaxel 25 q21d

Adult Chemotherapy - Medical Oncology

Metastatic Castration Resistant Prostate Cancer



CC2300 00101 06 2020

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** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $90 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- 45 minutes prior to CABAZItaxel: dexamethasone 8 mg IV** in 50 mL normal saline over 15 minutes on day 1
- 30 minutes prior to CABAZItaxel: diphenhydramine 50 mg IV** in 50 mL normal saline over 20 minutes on day 1
- 30 minutes prior to CABAZItaxel: famotidine 20 mg IV** in 50 mL normal saline over 20 minutes on day 1
- Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

- prednisone 5 mg PO** bid on days 1 to 21

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- CABAZItaxel 25 mg/m² X BSA = _____ mg**
 - Dose modification: **CABAZItaxel 25 mg/m² X BSA - _____ % = _____ mg**
- IV** in 250 mL normal saline PVC Free over 60 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.