

Doctor's Order Sheet  
**aXitinib 3 mg Regimen**  
**ARIA Protocol Name: aXitinib 3mg BID**  
 Adult Chemotherapy - Medical Oncology  
 Metastatic Renal Cell Carcinoma



CC3110 0122 07 2020

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

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

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

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

**Allergies:**

**No Known**

Date: DD/MONTH/YYYY Planned Administration Date: 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**  $1.5 \times 10^9/L$  and platelets **greater than or equal to**  $100 \times 10^9/L$ , otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Blood pressure assessed.
- Proteinuria assessed.
- Toxicities recovered to less than or equal to grade 2

**PREMEDICATIONS:** None recommended

Other: \_\_\_\_\_

**CHEMOTHERAPY (FOR COMMUNITY PHARMACY):**

**aXitinib 3 mg**  
**PO bid**

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.