

CISplatin 20 - etoposide 100

Regimen (Part I)

ARIA Protocol Name: Cisp20Etop100 D1-5

Adult Chemotherapy - Medical Oncology

Germ Cell Cancer Therapy



CC3080 0119 07 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:

- CBC and differential assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- fosaprepitant 150 mg IV in 150 mL normal saline over 30 minutes on day 1
- ondansetron 16 mg PO on days 1 to 5
- dexamethasone 12 mg PO on day 1
- dexamethasone 8 mg PO on days 2 to 5
- Other: _____

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.

Cancer Care Program

Doctor's Order Sheet

CISplatin 20 - etoposide 100

Regimen (Part II)

ARIA Protocol Name: Cisp20Etop100 D1-5

Adult Chemotherapy - Medical Oncology

Germ Cell Cancer Therapy

Name: _____

HCN: _____

Date of Birth: _____



CC3080 0119 07 2020

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

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

normal saline 500 mL IV hydration over 30 minutes pre-chemotherapy on days 1 to 5

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

etoposide 100 mg/m² X BSA = _____ mg

Dose modification: etoposide 100 mg/m² X BSA - _____ % = _____ mg

IV in 500 mL normal saline PVC Free bag over 45 minutes on days 1 to 5

CISplatin 20 mg/m² X BSA = _____ mg

Dose modification: CISplatin 20 mg/m² X BSA - _____ % = _____ mg

IV in 250 mL normal saline infused at 1 mg/min on days 1 to 5

POST CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

filgrastim (Brand: _____) _____ mcg subcutaneous daily for 7 days starting on day 7

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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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