CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

CARBOplatin AUC 5 - PACLitaxel 175 Regimen (Part I)

ARIA Protocol Name: Carb AUC 5 Pac 175

Adult Chemotherapy - Medical Oncology

Advanced Urothelial Carcinoma Therapy

CC3190 0130 08 2020

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 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- Creatinine Clearance assessed.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **45 minutes prior to PACLitaxel: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1

☐ **30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV** in 50 mL normal saline over 20 minutes on day 1

☐ **30 minutes prior to PACLitaxel: famotidine 20 mg IV** in 50 mL normal saline over 20 minutes on day 1

☐ **ondansetron 16 mg PO** on day 1

☐ 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: _____

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CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CARBOplatin AUC 5 - PACLitaxel 175 Regimen (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Carb AUC 5 Pac 175

Adult Chemotherapy - Medical Oncology

Advanced Urothelial Carcinoma Therapy

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **PACLitaxel 175 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **PACLitaxel 175 mg/m²** X BSA - _____% = _____ **mg**

IV in 500 mL normal saline PVC Free over 180 minutes on day 1

☐ **CARBOplatin AUC 5** = _____ **mg**

☐ Dose modification: **CARBOplatin AUC 5** - _____% =_____ **mg**

IV in 250 mL normal saline over 30 minutes on day 1

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

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Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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