CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

mitoXANTRONE 12 – prednisone 5 mg

Regimen

ARIA Protocol Name: MITOXPRED

Adult Chemotherapy - Medical Oncology

Metastatic Castration Resistant Prostate Cancer

CC3240 0135 09 2020

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: 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** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **ondansetron 16 mg PO** on day 1

☐ **dexamethasone 8 mg PO** on day 1

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **mitoXANTRONE 12 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **mitoXANTRONE 12 mg/m²** X BSA - _____% = _____ **mg**

IV PUSH qs to 50 mL normal saline over 10 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.