CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

BEP Days 1 - 5, 9 & 16 Regimen:

CISplatin 20 - etoposide 100 - bleomycin 30 units

(Part I)

ARIA Protocol Name: BEP Days 1-5, 9 & 16

Adult Chemotherapy - Medical Oncology

Curative Germ Cell Cancer Therapy

CC3040 0115 09 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:

- 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

☐ **dexamethasone 12 mg PO** on day 1

☐ **dexamethasone 8 mg PO** on days 2 to 5

☐ **ondansetron 16 mg PO** on days 1 to 5

☐ **hydrocortisone 100 mg IV** on days 2, 9 and 16

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

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

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: _____

CANCERCare
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Cancer Care Program

Doctor's Order Sheet

BEP Days 1-5, 9 & 16 Regimen:

CISplatin 20 - etoposide 100 - bleomycin 30 units

(Part II)

ARIA Protocol Name: BEP Days 1-5, 9 & 16

Adult Chemotherapy - Medical Oncology

Curative Germ Cell Therapy

Name:

HCN:

Date of Birth:

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **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

☐ **etoposide 100 mg/m²** X BSA = _____ **mg**

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

IV in 500 to 1000 mL normal saline PVC Free bag over 45 to 75 minutes on days 1 to 5

☐ **bleomycin 30 unit**

IV in 50 mL normal saline over 10 minutes on days 2, 9 and 16

POST CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **filgrastim** (Brand:_____) _____**mcg subcutaneous** daily on days 7 to 14 (except on the day of bleomycin) for a total of 7 doses

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.