

Doctor's Order Sheet

**SUNItinib (4 of 6) Regimen**  
**ARIA Protocol Name: SUNI50 (4 of 6)**  
Adult Chemotherapy - Medical Oncology  
Palliative Renal Cell Carcinoma



CC3380 0149 11 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: 42 days** Date of previous cycle: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- ANC **greater than or equal to**  $1 \times 10^9/L$  and platelets **greater than or equal to**  $75 \times 10^9/L$ , otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

**PREMEDICATIONS:** None recommended

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

**CHEMOTHERAPY (FOR COMMUNITY PHARMACY):**

- SUNItinib 50 mg PO** daily on days 1 to 28
- Dose modification: **SUNItinib 37.5 mg PO** daily on days 1 to 28
  - Dose modification: **SUNItinib 25 mg PO** daily on days 1 to 28

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.