

Doctor's Order Sheet

PAZOpanib Regimen
ARIA Protocol Name: PAZOpanib Daily
Adult Chemotherapy - Medical Oncology
Palliative Renal Cell Carcinoma



CC3360 0147 12 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: 30 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):

- PAZOpanib 800 mg PO** daily on days 1 to 30
- Dose modification: **PAZOpanib 400 mg PO** daily on days 1 to 30
 - Dose modification: **PAZOpanib 200 mg PO** daily on days 1 to 30

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.