

Doctor's Order Sheet

temsirolimus 25 mg Regimen
ARIA Protocol Name: Temsirolimus25
Adult Chemotherapy - Medical Oncology
Advanced Renal Cell Carcinoma



CC3390 0150 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: 28 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 (FOR HOSPITAL PHARMACY):

diphenhydrAMINE 50 mg IV on days 1, 8, 15 and 22

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

temsirolimus 25 mg

Dose modification: **temsirolimus 20 mg**

Dose modification: **temsirolimus 15 mg**

IV in 250 mL normal saline PVC Free over 30 to 60 minutes on days 1, 8, 15 and 22

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.