CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CARBOplatin AUC 5 - PACLitaxel 175 Regimen (Part I)

ARIA Protocol Name: Carb AUC 5 Pac 175

Adult Chemotherapy - Gynecologic Oncology
Uterine, Cervical, Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Carcinoma Therapy

Name:

HCN:

Date of Birth:

CC2110 0082 05 2021

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 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **45 minutes prior to PACLitaxel: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1
☐ **30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV** in 50 mL normal saline over 15 minutes on day 1
☐ **30 minutes prior to PACLitaxel: famotidine 20 mg IV** in 50 mL normal saline over 15 minutes on day 1
☐ **30 minutes prior to CARBOplatin: ondansetron 8 mg PO** on day 1
☐ Other: ______________________________

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: ____________________

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CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CARBOplatin AUC 5 - PACLitaxel 175 Regimen (Part II)

ARIA Protocol Name: Carb AUC 5 Pac 175

Adult Chemotherapy - Gynecologic Oncology

Uterine, Cervical, Epithelial Ovarian, Primary Peritoneal,or Fallopian Tube Carcinoma Therapy

Name:

HCN:

Date of Birth:

CC2110 0082 05 2021

Weight: _________kg Height:___________________________cm Body Surface Area (BSA) = _______________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **PACLitaxel 175 mg/m^2** X BSA = ___________ **mg**

☐ Dose modification: **PACLitaxel 175 mg/m^2** X BSA - _________% = ___________ **mg**

IV in 500 mL normal saline PVC Free over 180 minutes on day 1

☐ **CARBOplatin AUC 5 = ___________ mg**

☐ Dose modification: **CARBOplatin AUC 5** - _________% =_________ **mg**

IV in 250 mL normal saline over 30 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: ____

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