



Doctor's Order Sheet
CISplatin 75 Regimen
(Part I)

ARIA Protocol Name: Cisplatin 75

Adult Chemotherapy - Gynecologic Oncology
Epithelial Ovarian, Fallopian Tube, and Primary Peritoneal Carcinoma Therapy

Name: _____

HCN: _____

Date of Birth: _____



CC3560 0167 10 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 10⁹/L and platelets **greater than or equal to** 100 X 10⁹/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- fosaprepitant 150 mg IV** in 150 mL normal saline over 30 minutes on day 1
- dexamethasone 8 mg PO** on day 1
- 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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

Doctor's Order Sheet

CISplatin 75 Regimen

(Part II)

ARIA Protocol Name: Cisplatin 75

Adult Chemotherapy - Gynecologic Oncology

Epithelial Ovarian, Fallopian Tube, and Primary Peritoneal Carcinoma Therapy

Name: _____

HCN: _____

Date of Birth: _____



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Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

normal saline 1000 mL IV hydration over 60 minutes pre-CISplatin on day 1.

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

CISplatin 75 mg/m² X BSA = _____ mg + mannitol 25 grams

Dose modification: CISplatin 75 mg/m² X BSA - _____ % = _____ mg + mannitol 25 grams

IV in 500 mL normal saline infused at 1 mg/min on day 1

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

magnesium sulfate 2 grams and potassium chloride 20 mEq IV in 1000 mL normal saline over 120 minutes post-CISplatin 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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