

Doctor's Order Sheet  
**CISplatin 75 - PACLitaxel 175**  
Regimen  
(Part I)

**ARIA Protocol Name:** Cisp75 Pac175

Adult Chemotherapy - Gynecologic Oncology

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

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC3550 0166 01 2022

**Allergies:**

**No Known**

Date: DD/MONTH/YYYY  
Cycle \_\_\_\_\_ of \_\_\_\_\_

Planned Administration Date: DD/MONTH/YYYY  
**Cycle Duration: 21 days**

Date of previous cycle: DD/MONTH/YYYY

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

- ANC **greater than or equal to**  $1 \times 10^9/L$  and platelets **greater than or equal to**  $100 \times 10^9/L$ , 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
- 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  
Administer concurrently with famotidine via y-site
- 30 minutes prior to PACLitaxel: famotidine 20 mg IV** in 100 mL normal saline over 15 minutes on day 1  
Administer concurrently with diphenhydrAMINE via y-site
- 30 minutes prior to CISplatin: 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 - PACLitaxel 175  
Regimen**

(Part II)

**ARIA Protocol Name: Cisp75 Pac175**

Adult Chemotherapy - Gynecologic Oncology

Cervical, Uterine, Epithelial Ovarian, Primary Peritoneal or  
Fallopian Tube 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):**

**PACLitaxel 175 mg/m<sup>2</sup>** X BSA = \_\_\_\_\_ **mg**

Dose modification: **PACLitaxel 175 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_ % = \_\_\_\_\_ **mg**

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

**CISplatin 75 mg/m<sup>2</sup>** X BSA = \_\_\_\_\_ **mg + mannitol 25 grams**

Dose modification: **CISplatin 75 mg/m<sup>2</sup>** 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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