



Doctor's Order Sheet
Caelyx® 30 - CISplatin 50
Regimen
(Part I)

ARIA Protocol Name: Caelyx 30 CISplatin 50
Adult Chemotherapy - Gynecologic Oncology
Uterine Carcinoma Therapy



CC3600 0171 01 2022

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY
Cycle _____ of _____

Planned Administration Date: DD/MONTH/YYYY
Cycle Duration: **28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1.5 \times 10^9/L$ 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
- ondansetron 8 mg PO** on day 1
- dexamethasone 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

Caelyx® 30 - CISplatin 50

Regimen

(Part II)

ARIA Protocol Name: Caelyx 30 Cisplatin 50

Adult Chemotherapy - Gynecologic Oncology

Uterine Carcinoma Therapy



CC3600 0171 01 2022

Name: _____

HCN: _____

Date of Birth: _____

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):

Caelyx® (liposomal DOXOrubicin) 30 mg/m² X BSA = _____ mg

Dose modification: **Caelyx (liposomal DOXOrubicin) 30 mg/m²** X BSA - _____% = _____ mg

IV in 250 mL D5W over 60 minutes on day 1

To minimize the risk of infusion reactions, the initial dose is administered at a rate no greater than 1 mg/minute. If no infusion reaction is observed, subsequent infusions may be administered over 60 minutes.

CISplatin 50 mg/m² X BSA = _____ mg + **mannitol 25 grams**

Dose modification: **CISplatin 50 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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