

**gemcitabine 1000 (28 Day)**

Regimen

**ARIA Protocol Name: Gem1000 D1,8,15 Q28D**

Adult Chemotherapy - Medical Oncology

Advanced Sarcoma Cancer Therapy



CC3650 0176 01 2022

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**  $100 \times 10^9/L$ , otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

**PREMEDICATIONS (FOR HOSPITAL PHARMACY):**

**metoclopramide 10 mg PO** on days 1, 8 and 15

Other: \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

**gemcitabine 1000 mg/m<sup>2</sup>** X BSA = \_\_\_\_\_ mg

Dose modification: **gemcitabine 1000 mg/m<sup>2</sup>** X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg

**IV** in 250 mL normal saline over 30 minutes on days 1, 8 and 15

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.