

Doctor's Order Sheet

**CARBOplatin AUC 5 -  
PACLitaxel 175 - Kanjinti®  
(trastuzumab) 6 mg/kg Cycles  
2 to 6 Regimen (Part I)**

**ARIA Protocol Name:** CarbAUC5 Pac175 Kanjinti (trastuzumab)

Adult Chemotherapy - Gynecologic Oncology

Advanced Endometrial Cancer Therapy



CC3830 0194 05 2022

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

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

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

**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.
- LFT's 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  
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.
- ☐ **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.

**CARBOplatin AUC 5 -  
PACLitaxel 175 - Kanjinti®  
(trastuzumab) 6 mg/kg Cycles  
2 to 6 Regimen (Part II)**

**ARIA Protocol Name:** CarbAUC5 Pac175 Kanjinti (trastuzumab)

Adult Chemotherapy - Gynecologic Oncology

Advanced Endometrial Cancer Therapy



CC3830 0194 05 2022

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

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

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

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

**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

☐ **CARBOplatin AUC 5 = \_\_\_\_\_ mg**

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

**IV** in 250 mL normal saline over 30 minutes on day 1

☐ **Kanjinti® (trastuzumab) 6 mg/kg X Weight (kg) = \_\_\_\_\_ mg**

**IV** in 250 mL normal saline over 60 minutes on day 1

Cycles 3 - 6 can be administered over 30 minutes if no adverse reaction

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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