CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FLOT Regimen:

DOCEtaxel 50 - OXALIplatin 85 - leucovorin 200 - fluorouracil 2600 (Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Doce50 Oxali85 5-FU2600

Adult Chemotherapy - Medical Oncology

Perioperative / Advanced Gastric or Esophagogastric Cancer Therapy

CC1900 0061 06 2022

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 14 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 8 mg PO** bid for 3 days starting the day before chemotherapy

Patient must receive a minimum of three doses prior to receiving treatment

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **ondansetron 8 mg PO** 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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CANCERCare
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Cancer Care Program

Doctor's Order Sheet

FLOT Regimen:

DOCEtaxel 50 - OXALIplatin 85 - leucovorin 200 - fluorouracil 2600 (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Doce50 Oxali85 5-FU2600

Adult Chemotherapy - Medical Oncology

Perioperative / Advanced Gastric or Esophagogastric Cancer Therapy

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **DOCEtaxel 50 mg/m²** X BSA **=** _____ **mg**

☐ Dose modification: **DOCEtaxel 50 mg/m²** X BSA - _____% = _____ **mg**

IV in 100 to 250 mL normal saline PVC Free bag over 60 minutes on day 1

☐ **OXALIplatin 85 mg/m²** X BSA **=** _____ **mg**

☐ Dose modification: **OXALIplatin 85 mg/m²** X BSA - _____% = _____ **mg**

IV in 500 mL D5W over 120 minutes on day 1

☐ **leucovorin 200 mg/m²** X BSA **=** _____ **mg**

☐ Dose modification: **leucovorin 200 mg/m²** X BSA - _____% = _____ **mg**

IV in 250 mL D5W over 120 minutes on day 1

(OXALIplatin and leucovorin may be infused over the same 120 minute period)

☐ **fluorouracil 2600 mg/m²** X BSA=_____**mg**

☐ Dose modification: **fluorouracil 2600 mg/m²** X BSA - _____% = _____**mg**

continuous **IV** in 240 mL (total volume) D5W over 24 hours at a rate of 10 mL/hour starting on day 1

POST CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **filgrastim** (Brand:_____) _____**mcg subcutaneous** daily on days 5, 7, 9, 11 and 13

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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