CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

CARBOplatin AUC 5 - etoposide 100 – durvalumab 20 mg/kg Regimen

Name:

HCN:

Date of Birth:

ARIA Protocol Name: CarbAUC5 Etop100 D1-3 durvalumab 20 mg/kg - Small Cell

Adult Chemotherapy - Medical Oncology

Advanced Small Cell Lung Cancer Therapy

CC4040 0215 07 2022

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: 21 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.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **ondansetron 8 mg PO** on days 1 to 3

☐ **dexamethasone 8 mg PO** on days 1 to 3

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **durvalumab 20 mg/kg** X Weight (kg) **= _____ mg (maximum dose 1500 mg)**

IV in 100 mL normal saline over 60 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

☐ **etoposide 100 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **etoposide 100 mg/m²** X BSA - _____% = _____ **mg**

IV in 500 mL normal saline PVC Free bag over 45 minutes on days 1 to 3

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.