CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

cyclophosphamide 50 mg

Regimen

ARIA Protocol Name: Cyclo50 PO Daily

Adult Chemotherapy - Gynecologic Oncology

Relapsed/Progressing Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Carcinoma

CC4500 0260 12/2022

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: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.0 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed. Creatinine clearance **greater than or equal** to 10 mL/min.

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **cyclophosphamide 50 mg PO** once daily on days 1 to 28
- ☐ Dose modification: **cyclophosphamide ____mg PO** daily on days 1 to 28
- ☐ Dose modification: **cyclophosphamide ____mg PO** daily on days 1 to 28

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.