CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

encorafenib 300 mg - PANitumumab 6 mg/kg

Regimen: (Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Encorafenib 300 mg Panitumumab 6 mg/kg
Adult Chemotherapy - Medical Oncology
BRAF V600E - Mutated Metastatic Colorectal Carcinoma

CC4790 0289 02 2023

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

MAY PROCEED WITH DOSES AS WRITTEN IF:

- CBC with differential assessed
- LFTs and Bilirubin assessed
- Electrolytes, magnesium and calcium assessed.

PREMEDICATIONS:

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY): magnesium level _____

☐ **magnesium sulfate 2G IV** in 50 mL normal saline over 120 minutes for hypomagnesemia

OR

☐ **magnesium sulfate 4G IV** in 100 mL normal saline over 240 minutes for hypomagnesemia

☐ 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: _____

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

encorafenib 300 mg - PANitumumab 6 mg/kg

Regimen: (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: Encorafenib 300 mg Panitumumab 6 mg/kg

Adult Chemotherapy - Medical Oncology

BRAF V600E - Mutated Metastatic Colorectal Carcinoma

CC4790 0289 02 2023

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

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **encorafenib 300 mg**

☐ Dose modification: **encorafenib 225 mg**

☐ Dose modification: **encorafenib 150 mg**

PO daily

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **PANitumumab 6 mg/kg** X weight (kg) = _____ **mg**

☐ Dose modification: **PANitumumab 6 mg/kg** X weight (kg) **-** _____% = _____ **mg**

IV in 100 mL normal saline (total volume) over 60 minutes using a 0.2 micron in-line filter on day 1

If tolerated, subsequent infusions can be administered over 30 minutes. For doses greater than 1000 mg, dilute in 150 mL normal saline (total volume) and administer over 90 minutes for ALL cycles.

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: _____