



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 Q28D
Adult Chemotherapy - Medical Oncology
BRAF V600E - Mutated Metastatic Colorectal Carcinoma



CC5210 0331 05 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: 28 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 60 minutes for hypomagnesemia

OR

magnesium sulfate 4G IV in 100 mL normal saline over 120 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: _____

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Doctor's Order Sheet
**encorafenib 300 mg -
PANitumumab 6 mg/kg**

Regimen: (Part II)

ARIA Protocol Name: encorafenib 300 mg panitumumab 6 mg/kg Q28D

Adult Chemotherapy - Medical Oncology

BRAF V600E - Mutated Metastatic Colorectal Carcinoma



CC5210 0331 05 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 continuously

Mitte: 30 days

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
and day 15

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: _____

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