

Doctor's Order Sheet

sacituzumab govitecan
10 mg/kg Regimen: Part I

ARIA Protocol Name: sacituzumab govitecan

Adult Chemotherapy - Medical Oncology

Relapsed or Refractory Metastatic Triple Negative Breast Cancer Therapy



CC5500 0360 06/2023

Name: _____

HCN: _____

Date of Birth: _____

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** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, otherwise notify Medical Oncologist.
- Creatinine Clearance assessed.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

fosaprepitant 150 mg IV in 150 mL normal saline over 30 minutes on day 1 and 8

dexamethasone 8 mg PO on days 1 and 8

ondansetron 8 mg PO on days 1 and 8

acetaminophen 650 mg PO on days 1 and 8

diphenhydrAMINE 50 mg IV in 50 mL normal saline over 15 minutes on days 1 and 8.

Administer concurrently with famotidine via y-site.

famotidine 20 mg IV in 100 mL normal saline over 15 minutes on days 1 and 8.

Administer concurrently with diphenhydrAMINE via y-site.

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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

Doctor's Order Sheet

sacituzumab govitecan
10 mg/kg Regimen: Part II

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CC5500 0360 06 2023

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- sacituzumab govitecan 10 mg/kg X Weight (kg) = _____ mg**
 - Dose modification: **sacituzumab govitecan 10 mg/kg X Weight (kg) - _____ % = _____ mg**
- IV** in 500 mL normal saline over 180 minutes on days 1 and 8 (observe for 30 minutes post-infusion)
- If the infusion is well tolerated:**
 - Subsequent infusions can be administered over 60 minutes (observe for 30 minutes post-infusion)

HYDRATION/SUPPORTIVE CARE MEDICATIONS (FOR HOSPITAL PHARMACY):

- atropine 0.4 mg IV prn** for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis, or flushing.

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