CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

# **sotorasib 960 mg** Regimen

**ARIA Protocol Name:** sotorasib

Adult Chemotherapy - Medical Oncology

KRAS G12C-mutation Non-Small Cell Lung Cancer Therapy

Name:

HCN:

Date of Birth:

CC5540 0364 12 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: 30 days** Date of previous cycle: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

**PREMEDICATIONS:** None recommended

☐ Other: _____

**CHEMOTHERAPY (FOR COMMUNITY PHARMACY):**

☐ **sotorasib 960 mg PO** daily on days 1 to 30
- ☐ Dose modification: **sotorasib 480 mg PO** daily on days 1 to 30
- ☐ Dose modification: **sotorasib 240 mg PO** daily on days 1 to 30

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.