CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

temozolomide 150/200 Regimen

ARIA Protocol Name: temozolomide 150/200

Adult Chemotherapy - Medical Oncology

Malignant Brain Tumour Therapy

CC6210 0431 12 2023

Name:

HCN:

Date of Birth:

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** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR COMMUNITY PHARMACY):

☐ **30 minutes prior to temozolomide**: **ondansetron 8 mg PO** daily on days 1 to 5

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

Cycle 1

☐ **temozolomide 150 mg/m²** X BSA = _____ **mg PO** daily on days 1 to 5

☐ Dose modification: **temozolomide 100 mg/m²** X BSA = _____ mg **PO** daily on days 1 to 5

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist.

Cycles 2+

☐ **temozolomide 200 mg/m²** X BSA = _____ **mg PO** daily on days 1 to 5

☐ Dose modification: **temozolomide 150 mg/m²** X BSA = _____ mg **PO** daily on days 1 to 5

☐ Dose modification: **temozolomide 100 mg/m²** X BSA = _____ mg **PO** daily on days 1 to 5

This prescription is NOT eligible for pharmacist prescribing by dispensing pharmacist.

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.