CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

everolimus 10 mg Regimen

ARIA Protocol Name: everolimus 10 Kidney/Renal

Adult Chemotherapy - Medical Oncology

Advanced Renal Cell Carcinoma

CC6680 0488 04/2024

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:

- ANC **greater than or equal to** 1 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **everolimus 10 mg**

☐ Dose modification: **everolimus 10 mg** - _____% = _____ **mg**

PO daily (take on an empty stomach or after a fat-free meal)

HYDRATION/SUPPORTIVE CARE (FOR COMMUNITY PHARMACY):

☐ **dexamethasone 0.1 mg/mL suspension ORALLY** Swish and spit 10 mL four times daily for 8 weeks, patients may continue treatment beyond 8 weeks at the physician's discretion. Swish around mouth for a minimum of 2 minutes then spit out, do not swallow. Do not eat or drink for 1 hour after using mouthwash.

Mitte:1200 mL Refill:1

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.