Cancer Care Program

Doctor’s Order Sheet

CAPOX nivolumab Regimen: **nivolumab 4.5 mg/kg - OXALIplatin 130 - capecitabine 1000** (Part I)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: CAPOX nivolumab
Adult Chemotherapy - Medical Oncology
Locally Advanced or Metastatic Esophageal, Gastroesophageal, or Gastric Cancer

CC5720 0382 08/2023

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY ____________ DD/MONTH/YYYY Planned Administration

Date: ______________________________

MAY PROCEED WITH DOSES AS WRITTEN IF: DD/MONTH/YYYY

- ANC **greater than or equal to** 1.2 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Medical Oncologist
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **ondansetron 8 mg PO** on day 1

☐ **dexamethasone 8 mg PO** on day 1

☐ 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.

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet
CAPOX nivolumab Regimen:
nivolumab 4.5 mg/kg - OXALIplatin 130 - capecitabine 1000 (Part II)

ARIA Protocol Name: CAPOX nivolumab
Adult Chemotherapy - Medical Oncology
Locally Advanced or Metastatic Esophageal, Gastroesophageal, or Gastric Cancer

Name:

HCN:

Date of Birth:

CC5720 0382 08/2023

Weight: ___________kg Height:________________cm Body Surface Area (BSA) = ______________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **nivolumab 4.5 mg/kg** X Weight (kg) = ___________ **mg (maximum dose 360 mg)**
IV in 50 mL normal saline over 30 minutes on day 1

☐ **OXALIplatin 130 mg/m^2** X BSA = _______**mg**
☐ Dose modification: **OXALIplatin 130 mg/m^2** X BSA - ______% = __________**mg**
IV in 500 mL D5W over 120 minutes on day 1

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **capecitabine 1000 mg/m^2** X BSA = _________**mg**
☐ Dose modification: **capecitabine 1000 mg/m^2** X BSA - ______% = ________**mg**
PO bid with food on days 1 to 14

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: ____

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