CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

ripretinib Escalated Dose Regimen

ARIA Protocol Name: ripretinib150 bid

Adult Chemotherapy - Medical Oncology

Advanced Gastrointestinal Stromal Cell Tumour (GIST) Cancer Therapy

CC6510 0461 02 2024

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: 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** 50 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Arthralgia and Myalgia assessed.
- Blood pressure assessed.
- Skin changes assessed.

PREMEDICATIONS: None recommended

☐ Other: ____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **ripretinib 150 mg PO** bid

☐ Dose modification: **ripretinib 100 mg PO** bid

☐ Dose modification: **ripretinib 150 mg PO** daily

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.