

Doctor's Order Sheet

**ripretinib Standard Dose**

Regimen

**ARIA Protocol Name:** ripretinib150 daily

Adult Chemotherapy - Medical Oncology

Advanced Gastrointestinal Stromal Cell Tumour (GIST) Cancer Therapy

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC6500 0460 02 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**  $1 \times 10^9/L$  and platelets **greater than or equal to**  $50 \times 10^9/L$ , 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** daily

Dose modification: **ripretinib 100 mg PO** daily

Dose modification: **ripretinib 50 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.