

Doctor's Order Sheet
PACLitaxel 80 Regimen
(Part I)

ARIA Protocol Name: Paclitaxel 80 GI

Adult Chemotherapy - Medical Oncology

Metastatic or Recurrent Adenocarcinoma or Squamous Cell Gastroesophageal Cancer Therapy



CC7000 0520 10/2024

Name: _____

HCN: _____

Date of Birth: _____

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

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

45 minutes prior to PACLitaxel: dexamethasone 10 mg IV in 50 mL normal saline over 15 minutes on days 1, 8 and 15

30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV in 50 mL normal saline over 15 minutes on days 1, 8 and 15

Administer concurrently with famotidine via y-site.

30 minutes prior to PACLitaxel: famotidine 20 mg IV in 100 mL normal saline over 15 minutes on days 1, 8 and 15.

Administer concurrently with diphenhydrAMINE via y-site.

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: _____

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Doctor's Order Sheet
PACLitaxel 80 Regimen
(Part II)

ARIA Protocol Name: Paclitaxel 80 GI
Adult Chemotherapy - Medical Oncology
Metastatic or Recurrent Adenocarcinoma or Squamous Cell Gastroesophageal
Cancer Therapy



CC7000 0520 10/2024

Name: _____

HCN: _____

Date of Birth: _____

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

PACLitaxel 80 mg/m² X BSA = _____ mg

Dose modification: **PACLitaxel 80 mg/m² X BSA - _____ % = _____ mg**

IV in 250 mL normal saline PVC Free over 60 minutes on days 1, 8 and 15

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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