CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

vinCRIStine 1.5 - irinotecan 50 - temozolomide 100

Regimen (Part I)

ARIA Protocol Name: Vincristine Irinotecan Temozolomide Sarcoma

Adult Chemotherapy - Medical Oncology

Ewing's Sarcoma Therapy

CC7050 0525 11/2024

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: 21 days** Date of previous cycle: DD/MONTH/YYYY__________

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.
- Neurotoxicity assessment complete

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **ondansetron 8 mg PO** on days 1 to 5

☐ **dexamethasone 8 mg PO** on days 1 to 5

☐ **dimenhyDRINATE 25-50 mg PO prn** pre-vinCRIStine on day 1

☐ Other: ____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **temozolomide 100 mg/m²** X BSA = ___________ mg

☐ Dose modification: **temozolomide 100 mg/m²** X BSA - ______% = __________**mg**

PO daily on days 1 to 5. Take 1 hour BEFORE irinotecan administration.

Take on an empty stomach, at least one hour before or at least 2 hours after a meal. Swallow whole with a glass of water.

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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CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

vincristine 1.5 - irinotecan 50 - temozolomide 100

Regimen (Part II)

ARIA Protocol Name: Vincristine Irinotecan Temozolomide Sarcoma

Adult Chemotherapy - Medical Oncology

Ewing's Sarcoma Therapy

Name:

HCN:

Date of Birth:

CC7050 0525 11/2024

Weight: ____________kg Height:________________cm Body Surface Area (BSA) = __________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **vinCRIStine 1.5 mg/m^2** X BSA = ___________ **mg (max dose 2 mg)**

☐ Dose modification: **vinCRIStine 1.5 mg/m^2** X BSA - ______% = _________**mg**

IV in 50 mL normal saline over 15 minutes on day 1

☐ **irinotecan 50 mg/m^2** X BSA = ___________ **mg**

☐ Dose modification: **irinotecan 50 mg/m^2** X BSA - ______% = _________**mg**

IV in 250 mL D5W over 90 minutes on days 1 to 5. Administer 1 hour AFTER temozolomide

HYDRATION/SUPPORTIVE CARE MEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **atropine 0.4 mg intravenous prn** for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis, or flushing on days 1 to 5. (Repeat up to 1.2 mg if needed)

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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