CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

dostarlimab 500 mg - Abraxane® (nab-PACLitaxel) 260 - CARBOplatin AUC 5

Regimen (Part I)

ARIA Protocol Name: dostarlimab500 Abraxane260 CarbAUC5 - Endometrial Adult Chemotherapy - Gynecologic Oncology

Primary Advanced or Recurrent dMMR/MSI-H Endometrial Cancer Treatment

Name:

HCN:

Date of Birth:

CC7150 0535 02 2025

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 Gynecologic 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.

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Doctor's Order Sheet

dostarlimab 500 mg – Abraxane® (nab-PACLitaxel) 260 - CARBOplatin AUC 5

Regimen (Part II)

Name:

HCN:

Date of Birth:

ARIA Protocol Name: dostarlimab500 Abraxane260 CarbAUC5 – Endometrial

Adult Chemotherapy - Gynecologic Oncology

Primary Advanced or Recurrent dMMR/MSI-H Endometrial Cancer Treatment

CC7150 0535 02 2025

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **dostarlimab 500 mg**

IV in 100 mL normal saline over 30 minutes on day 1

☐ **Abraxane® (nab-PACLitaxel) 260 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **Abraxane® (nab-PACLitaxel) 260 mg/m²** X BSA - _____% = _____ **mg**

IV in empty Viaflex bag over 30 minutes on day 1

☐ **CARBOplatin AUC 5 =** _____ **mg**

☐ Dose modification: **CARBOplatin AUC 5** - _____% =_____ **mg**

IV in 250 mL normal saline over 30 minutes on day 1

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: _____

CP-0491 2024/05