CANCERcare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Doctor's Order Sheet

CARBOplatin AUC5 - DOCEtaxel 75 Regimen (Part I)

Name

HCN

Date of Birth:

ARIA Protocol Name: CarbAUC5 desensitization Doce 75

Adult Chemotherapy - Gynecologic Oncology

Carboplatin hypersensitivity

CC7350 0555 05/2025

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 Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐**1 hour prior to CARBOplatin: cetirizine 20 mg PO**

☐**1 hour prior to CARBOplatin: acetaminophen 650 mg PO**

☐**1 hour prior to CARBOplatin: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on day 1

☐**45 minutes prior to CARBOplatin: famotidine 20 mg IV** in 100 mL normal saline over 15 minutes on day 1

☐**ondansetron 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: _____

CANCERCare
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Cancer Care Program

Doctor's Order Sheet

Name:

HCN:

Date of Birth:

CARBOplatin AUC 5 - DOCEtaxel 75 Regimen (Part II)

ARIA Protocol Name: CarbAUC5 desensitization Doce 75

Adult Chemotherapy - Gynecologic Oncology

Carboplatin hypersensitivity

CC7350 0555 05 2025

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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **CARBOplatin AUC 5 = _____ mg**

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

IV in 500 mL normal saline. Infuse CARBOplatin at the following rates:

Step 1: 2 mL/hour for 15 minutes

Step 2: 4 mL/hour for 15 minutes

Step 3: 6 mL/hour for 15 minutes

Step 4: 8 mL/hour for 15 minutes

Step 5: 10 mL/hour for 15 minutes

Step 6: 15 mL/hour for 15 minutes

Step 7: 30 mL/hour for 15 minutes

Step 8: 60 mL/hour for 15 minutes

Step 9: 80 mL/hour for 15 minutes

Step 10: 100 mL/hour for 15 minutes

Step 11: 120 mL/hour for 15 minutes

Step 12: 140 mL/hour for 15 minutes

Step 13: 160 mL/hour for 15 minutes

Step 14: 180 mL/hour for 15 minutes

Step 15: 200 mL/hour for 15 minutes

Step 16: 400 mL/hour for 15 minutes

Step 17: 600 mL/hour until infusion is complete

☐ **DOCEtaxel 75 mg/m^2** X BSA = _____ **mg**

☐ Dose modification: **DOCEtaxel 75 mg/m^2** X BSA - _____% = _____ **mg**

IV in 250 to 500 mL normal saline PVC Free over 60 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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.