CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

CARBOplatin AUC 6 - etoposide 150 Regimen

ARIA Protocol Name: CarbAUC6 Etop150 D1-3

Adult Chemotherapy - Medical Oncology

Central Nervous System Germ Cell Tumor Germinoma

CC7650 0585 07 2025

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 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):

☐ **fosaprepitant 150 mg IV in 150 mL normal saline over 30 minutes on day 1**

☐ **ondansetron 8 mg PO** on days 1 to 3

☐ **dexamethasone 8 mg PO** on days 1 to 3

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **CARBOplatin AUC 6** = _____ **mg**

☐ Dose modification: **CARBOplatin AUC 6** - _____% =_____ **mg**

IV in 250 mL normal saline over 60 minutes on day 1

☐ **etoposide 150 mg/m^2** X BSA = _____ **mg**

☐ Dose modification: **etoposide 150 mg/m^2** X BSA - _____% = _____ **mg**

IV in 500 mL normal saline PVC Free bag over 120 minutes on days 1 to 3

POST-CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **filgrastim (Brand: _____) _____ mcg** subcutaneous daily for 7 days starting 24-48 hours post chemotherapy

☐ **peg-filgrastim (Brand:_____) 6 mg** subcutaneous for one dose 24-48 hours post chemotherapy

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.