Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

etoposide 500 - CISplatin 60

Regimen (Part I)

ARIA Protocol Name: EP 500/60 (Etop500Cis60) - Gyne

Adult Chemotherapy - Gynecologic Oncology

Gestational Trophoblastic Disease

CC7690 0589 08/2025

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_______ of ______ **Cycle Duration: 14 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 Gynecologic 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 day 1

☐ **dexamethasone 8 mg PO** on day 1

☐ Other: ______________________________

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **potassium chloride 20 mEq IV** in 1000 mL normal saline over 120 minutes pre-CISplatin 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.

CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

etoposide 500 - CISplatin 60

Regimen (Part II)

ARIA Protocol Name: EP 500/60 (Etop500Cis60) - Gyne

Adult Chemotherapy - Gynecologic Oncology

Gestational Trophoblastic Disease

CC7690 0589 08 2025

Weight: ____________kg Height:_________________cm Body Surface Area (BSA) = ____________________

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

etoposide total dose of 500 mg/m^2 to be given as 250 mg/m^2 in 2 divided doses given sequentially on day 1

☐ **etoposide 250 mg/m^2** X BSA = ___________ **mg**

☐ Dose modification: **etoposide 250 mg/m^2** X BSA - _________% = __________ **mg**

IV in 1000 mL normal saline PVC Free bag over 60 minutes on day 1

☐ **etoposide 250 mg/m^2** X BSA = ___________ **mg**

☐ Dose modification: **etoposide 250 mg/m^2** X BSA - _________% = __________ **mg**

IV in 1000 mL normal saline PVC Free bag over 60 minutes on day 1

☐ **CISplatin 60 mg/m^2** X BSA = ___________ **mg**

☐ Dose modification: **CISplatin 60 mg/m^2** X BSA - _________% =_________ **mg**

IV in 1000 mL normal saline over 120 minutes on day 1

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

☐ **magnesium sulfate 4 mmol and potassium chloride 20 mEq IV** in 1000 mL normal saline over 120 minutes post-CISplatin on day 1

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: ____

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