CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name :

HCN :

Date of Birth:

Doctor's Order Sheet

enfortumab vedotin 1.25 mg/kg Regimen

ARIA Protocol Name: enfortumab vedotin Bladder

Adult Chemotherapy - Medical Oncology

Urothelial Carcinoma

CC6070 0417 10/2023

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: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.0 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **metoclopramide 10 mg PO** on days 1, 8 and 15

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **enfortumab vedotin 1.25 mg/kg** X Weight (kg) **=** _____ **mg (maximum dose 125 mg)**

☐ Dose modification: **enfortumab vedotin 1 mg/kg** X Weight (kg) **=** _____ **mg (maximum dose 100 mg)**

☐ Dose modification: **enfortumab vedotin 0.75 mg/kg** X Weight (kg) **=** _____ **mg (maximum dose 75 mg)**

☐ Dose modification: **enfortumab vedotin 0.5 mg/kg** X Weight (kg) **=** _____ **mg (maximum dose 50 mg)**

IV in 50 mL normal saline over 30 minutes on days 1, 8 and 15. Observe for 60 minutes post infusion for cycle 1. Observation period not required after 3 consecutive doses with no reaction.

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.