

Doctor's Order Sheet
**gemcitabine 1000 -
PACLitaxel 100** Regimen
(Part I)

ARIA Protocol Name: Gem1000 Pac100 D1,8,15 Q28D

Adult Chemotherapy - Medical Oncology

Metastatic Germ Cell Cancer



CC6180 0428 11 2023

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

☐ **No Known**

Date: DD/MONTH/YYYY
Cycle _____ of _____

Planned Administration Date: DD/MONTH/YYYY
Cycle Duration: 28 days

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1.5 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- ☐ **45 minutes prior to PACLitaxel: dexamethasone 20 mg IV** in 50 mL normal saline over 15 minutes on days 1, 8 and 15
- ☐ **30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV** in 50 mL normal saline over 15 minutes on days 1, 8 and 15
Administer concurrently with famotidine via y-site
- ☐ **30 minutes prior to PACLitaxel: famotidine 20 mg IV** in 100 mL normal saline over 15 minutes on days 1, 8 and 15
Administer concurrently with diphenhydrAMINE via y-site
- ☐ **metoclopramide 10 mg PO** on days 1, 8 and 15
- ☐ 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: _____

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Doctor's Order Sheet

**gemcitabine 1000 -
PACLitaxel 100 Regimen**

(Part II)

ARIA Protocol Name: Gem1000 Pac100 D1,8,15 Q28D

Adult Chemotherapy – Medical Oncology

Metastatic Germ Cell Cancer



CC6180 0428 11 2023

Name: _____

HCN: _____

Date of Birth: _____

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **PACLitaxel 100 mg/m²** X BSA = _____ mg

☐ Dose modification: **PACLitaxel 100 mg/m²** X BSA - _____ % = _____ mg

IV in 250 mL normal saline PVC Free over 60 minutes on days 1, 8 and 15

☐ **gemcitabine 1000 mg/m²** X BSA = _____ mg

☐ Dose modification: **gemcitabine 1000 mg/m²** X BSA - _____ % = _____ mg

IV in 250 mL normal saline over 30 minutes on days 1, 8 and 15

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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