Cancer Care Program

Doctor's Order Sheet

Caelyx® 30 Regimen:

liposomal DOXOrubicin

ARIA Protocol Name: CAELYX 30 (Breast)

Adult Chemotherapy- Medical Oncology

Metastatic Breast Cancer Therapy

Name:

HCN:

Date of Birth:

CC1720 0043 06 2018

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 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.

PREMEDICATIONS:

☐ **metoclopramide 10 mg PO**

☐ Other: ___________________________

CHEMOTHERAPY:

☐ **Caelyx® (liposomal DOXOrubicin) 30 mg/m²** X BSA = ___________ mg IV in 250 mLs **D5W** over 60 minutes on day 1

☐ Dose modification: **30 mg/m²** X BSA - _________% = ___________ mg IV in 250 mLs **D5W** over 60 minutes on day 1

To minimize the risk of infusion reactions, the initial dose is administered at a rate no greater than 1 mg/minute. If no infusion reaction is observed, subsequent infusions may be administered over 60 minutes.

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.

CP-0043 2018/06