



Doctor's Order Sheet

Caelyx[®] 35 Regimen:

liposomal DOXOrubicin

Cancer Care Program

ARIA Protocol Name: CAELYX 35 (Breast)

Adult Chemotherapy- Medical Oncology

Metastatic Breast Cancer Therapy



CC1730 0044 062018

Name: _____

HCN: _____

Date of Birth: _____

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** $1 \times 10^9/L$ and platelets **greater than or equal to** $100 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.

PREMEDICATIONS

- metoclopramide 10 mg PO
- Other: _____

CHEMOTHERAPY:

- Caelyx[®] (liposomal DOXOrubicin) 35 mg/m² X BSA = _____ mg IV in 250 mLs D5W**
over 60 minutes on day 1
- Dose modification: **35 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.