CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet
AC PACLitaxel Dose Dense Regimen: **(Cycles 5-8)**
PACLitaxel (Part I)
ARIA Protocol Name: AC-PACLitaxel dose-dense
Adult Chemotherapy- Medical Oncology
Adjuvant Breast Cancer Therapy

Name:

HCN:

Date of Birth:

CC1800 0051 09 2019

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 Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

☐ **45 minutes prior to PACLitaxel: dexamethasone 20 mg IV in 50 mL normal saline over 20 minutes**
☐ **30 minutes prior to PACLitaxel: diphenhydraMINE 50 mg IV in 50 mL normal saline over 20 minutes**
☐ **30 minutes prior to PACLitaxel: famotidine 20 mg IV in 50 mL normal saline over 20 minutes**

If prior reaction to PACLitaxel:

☐ **dexamethasone 20 mg PO 12 hours and 6 hours prior to PACLitaxel and omit above IV dexamethasone**

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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CANCERCare
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Cancer Care Program

Doctor's Order Sheet

AC PACLitaxel Dose Dense Regimen: **(Cycles 5-8)**

PACLitaxel (Part II)

Name:

HCN:

Date of Birth

ARIA Protocol Name: AC-PACLitaxel dose-dense

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC1800 0051 09 2019

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY:

☐ **PACLitaxel 175 mg/m²** X BSA = _____ mg IV in 500 mL D5W (use non-PVC bag and non-PVC 0.22 micron in-line filter) over 180 minutes on day 1

☐ Dose modification: **175 mg/m²** X BSA - _____% = _____ mg IV in 500 mL D5W (use non-PVC bag and non-PVC 0.22 micron in-line filter) over 180 minutes on day 1

POST CHEMOTHERAPY:

☐ **filgrastim (Brand:_____)** _____ **mcg** subcutaneous daily for 7 days starting 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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