CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

TAC Regimen:

DOCEtaxel-DOXOrubicin-cyclophosphamide

(Part I)

ARIA Protocol Name: TAC

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC1890 0060 10 2019

Name:

HCN:

Date of Birth:

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 21 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS:

☐ **dexamethasone 8 mg PO bid x 3 doses starting the day before chemotherapy**
Patient must receive a minimum of three doses prior to receiving treatment

☐ **ondansetron 16 mg PO**

☐ **fosaprepitant 150 mg IV in 150 mL normal saline over 30 minutes**

OR

☐ **aprepitant 125 mg PO followed by 80 mg PO on days 2 and 3**

☐ 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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CANCERCare
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Doctor's Order Sheet

TAC Regimen:

DOCEtaxel-DOXOrubicin-cyclophosphamide

(Part II)

ARIA Protocol Name: TAC

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC1890 0060 10 2019

Name:

HCN:

Date of Birth:

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

HYDRATION/SUPPORTIVE CARE:

☐ **normal saline 1000 mL IV (hydration to be given before cyclophosphamide)**

CHEMOTHERAPY:

☐ **DOXOrubicin 50 mg/m²** X BSA = _____ mg IV push on day 1

☐ Dose modification: **50 mg/m²** X BSA - _____% = _____ mg IV push on day 1

☐ **cyclophosphamide 500 mg/m²** X BSA= _____mg IV in 100 mL normal saline over 60 minutes on day 1 (If dose is greater than 1000 mg, administer in 250 mL normal saline)

☐ Dose modification: **500 mg/m²** X BSA - _____% = _____ mg IV in 100 mL normal saline over 60 minutes on day 1

Doses greater than 1000 mg must be diluted in 250mLs normal saline

☐ **DOCEtaxel 75 mg/m²** X BSA = _____ mg IV in 250 mL normal saline (PVC Free bag) over 60 minutes on day 1 (If dose is greater than 185 mg, administer in 500 mL normal saline)

☐ Dose modification: **75 mg/m²** X BSA - _____% = _____ mg IV in 250 mL normal saline (PVC Free bag) over 60 minutes on day 1

POST CHEMOTHERAPY:

☐ **dexamethasone 4 mg PO bid x 3 doses starting the evening of chemotherapy**

☐ **filgrastim (Brand:_____) _____ mcg** subcutaneous daily for 7 days starting 24-48 hours post chemotherapy

☐ **pegfilgrastim (Brand:_____) 6 mg** subcutaneous x one dose 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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