

Doctor's Order Sheet  
 TC Regimen:  
**DOCEtaxel 75 -  
 cyclophosphamide 600 (Part I)**  
**ARIA Protocol Name: TC**  
 Adult Chemotherapy - Medical Oncology  
 Adjuvant Breast Cancer Therapy

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC1750 0046 01 2021

<b>Allergies:</b>	<input type="checkbox"/> <b>No Known</b>
Date: <u>DD/MONTH/YYYY</u> Planned Administration Date: <u>DD/MONTH/YYYY</u> Cycle <u>      </u> of <u>      </u> <b>Cycle Duration: 21 days</b> Date of previous cycle: <u>DD/MONTH/YYYY</u>	
<b>MAY PROCEED WITH DOSES AS WRITTEN IF:</b>	
<ul style="list-style-type: none"> <li>• ANC <b>greater than or equal to</b> 1.5 X 10<sup>9</sup>/L and platelets <b>greater than or equal to</b> 90 X 10<sup>9</sup>/L, otherwise notify Medical Oncologist.</li> <li>• LFTs and Bilirubin assessed.</li> <li>• Creatinine clearance assessed.</li> </ul>	
<b>PREMEDICATIONS (FOR COMMUNITY PHARMACY)</b>	
<input type="checkbox"/> <b>dexamethasone 8 mg PO</b> bid for 3 days starting the day before DOCEtaxel Patient must receive a minimum of three doses prior to receiving treatment. <input type="checkbox"/> Other: _____	
<b>PREMEDICATIONS (FOR HOSPITAL PHARMACY)</b>	
<input type="checkbox"/> <b>ondansetron 16 mg PO</b> on day 1 <input type="checkbox"/> 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: \_\_\_\_\_

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

Doctor's Order Sheet  
 TC Regimen:  
**DOCEtaxel 75 -  
 cyclophosphamide 600 (Part II)**  
**ARIA Protocol Name: TC**  
 Adult Chemotherapy - Medical Oncology  
 Adjuvant Breast Cancer Therapy

Name: \_\_\_\_\_  
 HCN: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_



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

**HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):**

normal saline 1000 mL IV over 60 minutes pre-cyclophosphamide on day 1

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

cyclophosphamide 600 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg

Dose modification: cyclophosphamide 600 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg

IV in 100 to 250 mL normal saline over 60 minutes on day 1

DOCEtaxel 75 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg

Dose modification: DOCEtaxel 75 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg

IV in 250 to 500 mL normal saline PVC Free bag over 60 minutes on day 1

**POST-CHEMOTHERAPY (FOR COMMUNITY PHARMACY):**

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

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Authorized Prescriber's Signature: \_\_\_\_\_ ID #: \_\_\_\_\_

Nurse's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_

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