

Doctor's Order Sheet
Caelyx® 20 Regimen:
liposomal DOXOrubicin 20
ARIA Protocol Name: CAELYX 20
 Adult Chemotherapy - Gynecological Oncology
 Epithelial Ovarian, Primary Peritoneal,
 or Fallopian Tube Carcinoma Therapy

Name: _____

HCN: _____

Date of Birth: _____



CC3500 0161 04 2021

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 Gynecologic Oncologist.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

metoclopramide 10 mg PO on day 1 and 15

Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

Caelyx® (liposomal DOXOrubicin) 20 mg/m² X BSA = _____ mg

Dose modification: Caelyx® (liposomal DOXOrubicin) 20 mg/m² X BSA - _____ % = _____ mg

IV in 250 mL D5W over 60 minutes on day 1 and 15

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.