CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

Caelyx® 40 Regimen:

liposomal DOXOrubicin 40

ARIA Protocol Name: CAELYX 40

Adult Chemotherapy - Gynecological Oncology

Epithelial Ovarian, Primary Peritoneal,

or Fallopian Tube Carcinoma Therapy

Name:

HCN:

Date of Birth:

CC2060 0077 05 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 X 10^9/L and platelets **greater than or equal to** 100 X 10^9/L, otherwise notify Gynecologic Oncologist.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **metoclopramide 10 mg PO**

☐ Other: _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Caelyx® (liposomal DOXOrubicin) 40 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **Caelyx® (liposomal DOXOrubicin) 40 mg/m²** X BSA - _____% = _____ **mg**

IV in 250 to 500 mL 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.

CP-0077 2021/05