

Doctor's Order Sheet
AC weekly PACLitaxel dose dense
Regimen: **(Cycles 5-8)**
PACLitaxel 80 (Part I)

ARIA Protocol Name: AC weekly PACLitaxel dose dense Cycles 5 to 8
Adult Chemotherapy- Medical Oncology
Adjuvant Breast Cancer Therapy



CC5580 0368 07/2023

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 10⁹/L and platelets **greater than or equal to** 100 X 10⁹/L, otherwise notify Medical Oncologist.
- Creatinine Clearance assessed.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- 45 minutes prior to PACLitaxel: dexamethasone 10 mg IV** in 50 mL normal saline over 15 minutes on days 1, 8 and 15.
- 30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV** in 50 mL normal saline over 15 minutes on day 1, 8 and 15. Administer concurrently with famotidine via y-site.
- 30 minutes prior to PACLitaxel: famotidine 20 mg IV** in 100 mL normal saline over 15 minutes on day 1, 8 and 15. Administer concurrently with diphenhydrAMINE via y-site.
- 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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Doctor's Order Sheet
AC weekly PACLitaxel dose dense
Regimen: **(Cycles 5-8)**

PACLitaxel 80 (Part II)

ARIA Protocol Name: AC weekly PACLitaxel dose dense Cycles 5 to 8
Adult Chemotherapy- Medical Oncology
Adjuvant Breast Cancer Therapy



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

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- PACLitaxel 80 mg/m² X BSA = _____ mg**
 - Dose modification: **PACLitaxel 80 mg/m² X BSA - _____ % = _____ mg**
- IV** in 250 mL normal saline PVC Free over 60 minutes on days 1, 8 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: _____

Name: _____

HCN: _____

Date of Birth: _____

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