

Doctor's Order Sheet
AC weekly PACLitaxel dose dense
Regimen: **(Cycles 1-4)**
DOXOrubicin 60 -
cyclophosphamide 600 (Part I)

ARIA Protocol Name: AC weekly PACLitaxel dose dense Cycles 1 to 4
Adult Chemotherapy- Medical Oncology
Adjuvant Breast Cancer Therapy



CC5570 0367 07 2023

Name: _____

HCN: _____

Date of Birth: _____

Allergies:

No Known

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

Cycle of

Cycle Duration: 14 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.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

fosaprepitant 150 mg IV in 150 mL normal saline over 30 minutes on day 1

ondansetron 16 mg PO on day 1

dexamethasone 12 mg PO on day 1

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 1-4)**

**DOXOrubicin 60 -
cyclophosphamide 600 (Part II)**

ARIA Protocol Name: AC weekly PACLitaxel dose dense Cycles 1 to 4

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy



CC5570 0367 07 2023

Name: _____

HCN: _____

Date of Birth: _____

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

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

sodium chloride 0.9% 1000 mL IV hydration over 60 minutes pre-cyclophosphamide on day 1.

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

DOXOrubicin 60 mg/m² X BSA = _____ **mg**

Dose modification: **DOXOrubicin 60 mg/m²** X BSA - _____ % = _____ **mg**

IV push on day 1

cyclophosphamide 600 mg/m² X BSA = _____ **mg**

Dose modification: **cyclophosphamide 600 mg/m²** X BSA - _____ % = _____ **mg**

IV in 250 mL normal saline 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

peg-filgrastim (Brand: _____) **6 mg subcutaneous** for one dose 24-48 hours post chemotherapy

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Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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