CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

pembrolizumab 2 mg/kg - PACLitaxel 80 - CARBOplatin AUC 1.5 - DOXOrubin 60 - cyclophospamide 600

Regimen: Cycles 5-8 (Part I)

ARIA Protocol Name: Pembro 2mg/kg Pac80 CarbAUC1.5; Pembro 2 mg/kg Doxo60 Cyclo600

Adult Chemotherapy - Medical Oncology

Untreated Triple Negative Breast Cancer Therapy

Name:

HCN:

Date of Birth:

CC5000 0310 04 2023

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 10^9/L and platelets **greater than or equal to** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.
- Creatinine clearance assessed.
- Thyroid function assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

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

☐ **dexamethasone 8 mg PO** on day 1

☐ **ondansetron 8 mg PO** on day 1

☐ Other: _____

HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):

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

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.

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Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

pembrolizumab 2 mg/kg - PACLitaxel 80 - CARBOplatin AUC 1.5 - DOXOrubin 60 - cyclophospamide 600

Regimen: Cycles 5-8 (Part II)

ARIA Protocol Name: Pembro 2mg/kg Pac80 CarbAUC1.5; Pembro 2 mg/kg Doxo60 Cyclo600

Adult Chemotherapy - Medical Oncology

Untreated Triple Negative Breast Cancer Therapy

CC5000 0310 04 2023

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **pembrolizumab 2 mg/kg** X Weight (kg) = _____ **mg (maximum dose 200 mg)**

IV in 50 mL normal saline over 30 minutes on day 1

☐ **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

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

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Authorized Prescriber's Signature: _____ ID #: _____

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

Nurse's Signature: _____

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