

Doctor's Order Sheet

**palbociclib 125 mg -
tamoxifen 20 mg
maintenance Regimen**

ARIA Protocol Name: palbociclib tamoxifen maintenance

Adult Chemotherapy - Medical Oncology

Estrogen-Receptor (ER)-positive, Human Epidermal Growth Factor
Receptor 2 (HER2)-negative Advanced/Metastatic Breast Cancer
Therapy

Name: _____

HCN: _____

Date of Birth: _____



CC6880 0508 09/2024

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: 84 days

Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** $1.0 \times 10^9/L$ and platelets **greater than or equal to** $50 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

palbociclib 125 mg PO daily on days 1 to 21, 29 to 49 and 57 to 77

Dose modification: **palbociclib 100 mg PO** daily on days 1 to 21, 29 to 49 and 57 to 77

Dose modification: **palbociclib 75 mg PO** daily on days 1 to 21, 29 to 49 and 57 to 77

PLUS

tamoxifen 20 mg PO daily continuously

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.