CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Doctor's Order Sheet

capivasertib 400 mg - fulvestrant 500 mg Regimen: Cycle 1

ARIA Protocol Name: capivasertib fulvestrant Compassionate

Adult Chemotherapy - Medical Oncology

HR positive, HER2 negative Locally Advanced or Metastatic Breast Cancer Therapy with one or more PIK3CA/AKT1/PTEN alterations

CC6730 0493 05 2024

Name:

HCN:

Date of Birth:

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:

- CBC with differential assessed.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ Other: ____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **fulvestrant 500 mg IM** on days 1 and 15

☐ **capivasertib 400 mg**

☐ Dose modification: **capivasertib 320 mg**

☐ Dose modification: **capivasertib 200 mg**

PO BID on days 1-4, 8-11, 15-18, and 22-25

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.