

Doctor's Order Sheet

**capivasertib 400 mg -  
fulvestrant 500 mg Regimen:**  
Cycles 2 +

**ARIA Protocol Name:** capivasertib fulvestrant Compassionate

Adult Chemotherapy - Medical Oncology

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



CC6740 0494 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 day 1
- 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.