

Doctor's Order Sheet

**ribociclib 600 mg – letrozole
2.5 mg Regimen**

ARIA Protocol Name: Ribociclib 600 Letrozole 2.5 Maintenance

Adult Chemotherapy - Medical Oncology

Advanced HR+/HER2 - Breast Cancer Therapy

Name: _____

HCN: _____

Date of Birth: _____



CC7290 0549 04 2025

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** $1 \times 10^9/L$ and platelets **greater than or equal to** $75 \times 10^9/L$, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- ribociclib 600 mg PO** daily on days 1 to 21, 29 to 49 and 57 to 77
- Dose modification: **ribociclib 400 mg PO** daily on days 1 to 21, 29 to 49 and 57 to 77
 - Dose modification: **ribociclib 200 mg PO** daily on days 1 to 21, 29 to 49 and 57 to 77
- letrozole 2.5 mg PO** daily continuously Mitte: 90 tablets Repeat x 3

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.