CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet
nab-PACLitaxel (Abraxane®)
Regimen

Abraxane® (nab-PACLitaxel) 260

ARIA Protocol Name: nab-PACLitaxel (Abraxane) 260 mg/m2

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC7740 0594 09/2025

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** 100 X 10^9/L, otherwise notify Medical Oncologist.
- Creatinine Clearance assessed.
- LFTs and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ Other: ____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **Abraxane® (nab-PACLitaxel) 260 mg/m²** X BSA =___________**mg**

☐ Dose modification: **Abraxane® (nab-PACLitaxel) 260 mg/m²** X BSA - _________% = ___________ **mg**

IV in Viaflex bag over 30 minutes 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.