CANCERCare
A PROGRAM OF EASTERN HEALTH

Cancer Care Program

Name:

HCN:

Date of Birth:

Doctor's Order Sheet

ribociclib 600 mg – fulvestrant 500 mg Regimen

ARIA Protocol Name: Fulvestrant Ribociclib 600 Maintenance

Adult Chemotherapy - Medical Oncology

ER-positive/HER2-negative Advanced or Metastatic Breast Cancer Therapy

CC7880 0608 10 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 X 10^9/L and platelets **greater than or equal to** 75 X 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

☐ **fulvestrant 500 mg IM** on days 1, 29 and 57

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.