CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

abemaciclib 150 mg - letrozole 2.5 mg

Regimen

ARIA Protocol Name: abemaciclib letrozole maintenance

Adult Chemotherapy - Medical Oncology

Adjuvant HR+/HER2- Breast Cancer Therapy

CC7920 0612 12 2025

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: 90 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** 50 X 10^9/L, otherwise notify Medical Oncologist.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS: None recommended

☐ Other: ____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

☐ **abemaciclib 150 mg PO** BID for 90 days continuously

- ☐ Dose modification: **abemaciclib 100 mg PO** BID for 90 days continuously
- ☐ Dose modification: **abemaciclib 50 mg PO** BID for 90 days continuously

☐ **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.