

Doctor's Order Sheet

**ribociclib 400 mg – letrozole  
2.5 mg Regimen**

**ARIA Protocol Name:** ribociclib 400 letrozole 2.5 - eBC maintenance

Adult Chemotherapy - Medical Oncology

Adjuvant Breast Cancer Therapy



CC9200 0640 04 2026

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: 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 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.