Name:

HCN:

Date of Birth:

CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FEC-100 Regimen:

fluorouracil – epiRUBicin – cyclophosphamide (Part I)

ARIA Protocol Name: FEC

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC1690 0040 06 2018

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.
- LFTs and Bilirubin assessed.
- Creatinine clearance assessed.

PREMEDICATIONS

☐ **fosaprepitant 150 mg IV in 150 mLs normal saline over 30 minutes**

OR

☐ **aprepitant 125 mg PO followed by 80 mg PO on days 2 and 3**

☐ **ondansetron 16 mg PO**

☐ **dexamethasone 12 mg PO**

HYDRATION/SUPPORTIVE CARE

☐ **Start IV infusion with normal saline 1000 mLs and infuse with fluorouracil and epiRUBicin so that 1000 mLs is infused prior to cyclophosphamide.**

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.

Name:

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CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FEC-100 Regimen:

fluorouracil – epiRUBicin – cyclophosphamide

(Part II)

ARIA Protocol Name: FEC

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC1690 0040 06 2018

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY:

☐ **epiRUBicin 100 mg/m²** X BSA = _____ mg IV push on day 1

☐ Dose modification: **100 mg/m²** X BSA - _____% = _____ mg IV push on day 1

☐ **fluorouracil 500 mg/m²** X BSA **= _____** mg IV in 100 mLs D5W over 30 minutes on day 1

☐ Dose modification: **500 mg/m² X BSA - _____% = _____** mg IV in 100 mLs D5W over 30 minutes on day 1

☐ **cyclophosphamide 500 mg/m²** X BSA= _____mg IV in 100 mLs normal saline over 60 minutes on day 1 (doses greater than 1000 mg must be diluted in 250 mLs normal saline)

☐ Dose modification: **500 mg/m²** X BSA - _____% = _____ mg IV in 100 mLs normal saline over 60 minutes on day 1

POST CHEMOTHERAPY

☐ **Neupogen® (filgrastim)** _____ **mcg** subcutaneous daily for 7 days starting 24-48 hours post chemotherapy

☐ **Grastofil® (filgrastim)** _____ **mcg** subcutaneous daily for 7 days starting 24-48 hours post chemotherapy.

☐ **Neulasta® (peg-filgrastim) 6 mg** subcutaneous x one dose 24-48 hours post chemotherapy.

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: _____

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