CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FEC-D Regimen (DOCEtaxel arm):

DOCEtaxel (Cycles 4-6)

ARIA Protocol Name: FEC-D

Adult Chemotherapy- Medical Oncology

Adjuvant Breast Cancer Therapy

CC1700 0041 06 2018

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: 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** 90 X 10^9/L, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

PREMEDICATIONS

☐ **dexamethasone 8 mg PO bid x 3 days starting the day before chemotherapy**
(Patient must receive a minimum of three doses prior to receiving treatment)

☐ Other:

CHEMOTHERAPY:

☐ **DOCEtaxel 100 mg/m²** X BSA = _____ mg IV in 250 mLs normal saline (non-PVC bag) over 60 minutes on day 1 (If dose is greater than 185 mg, administer in 500 mLs normal saline)

☐ Dose modification: **100 mg/m²** X BSA - _____% = _____ mg IV in 250 mLs normal saline (non-PVC bag) 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: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

CP-0041 2018/06