

Adult Outpatient Chemotherapy Order Form (page 1 of 1)

Diagnosis / Indications: Breast Cancer
 Regimen: Liposomal Doxorubicin Q21DAYS
 Cycle #: _____
 References: Ranson, MB, et al. J Clin Oncol 1997;15:3185-91
 Begin Therapy Day #1 (____/____/____)

Patient Height: _____ cm
 Weight: Actual _____ kg Ideal: _____ kg Used: _____ kg
 Body Surface Area: Actual: _____ Ideal: _____ Used: _____
 Allergies (reactions): _____

 Lifetime Dose Liposomal Doxorubicin: _____

Chemotherapy:

	DRUG (Oral or injectable)	PROTOCOL DOSAGE (Per m ² or Per kg)	PATIENT'S DOSE	ROUTE / FREQUENCY	GIVE ON DAYS
1	Liposomal Doxorubicin	40 mg/m ²		IV	Day 1
	Fluid / Volume: 250 mL D5W [EF on _____ = _____ %]		Flow Rate or Infusion Time: Begin with 1 mg/min. If well tolerated, increase rate to infuse over 1 hour.		
2					
	Fluid / Volume:		Flow Rate or Infusion Time:		

Follow-up appt.: _____ with labs _____

Specific Administration Instructions/Requirements:

- Institute extravasation protocol in the event of a suspected extravasation
 ANC greater than 1,000 ANC greater than 1,500 Platelets greater than 100,000
- Monitor for hypersensitivity / allergic reaction. If suspected, then follow hypersensitivity / anaphylaxis orders per the Emergency Physician's Order protocol.

Labs: CBC w/diff CMP BMP LFTs Other: _____

Pre-Medications:

- Dexamethasone 12 mg IV x 1

PRN Medications (please check appropriate meds):

Diphenhydramine 25 mg IV x 1 50 mg IV x 1
 Lorazepam 1 mg IV x 1 Prochlorperazine 10 mg IV x 1 Promethazine 25 mg IV x 1

Take Home Medications (please check appropriate meds):

Prochlorperazine 10 mg PO q6hr PRN nausea and vomiting (# _____) OR
 Promethazine 25 mg PO q6hr PRN nausea and vomiting (# _____)

Special Instructions / Extra Orders: _____

Date _____ Time _____ Physician / PA / RPh _____ Provider # _____ Beeper # _____

Date _____ Time _____ Signature of Oncology Attending / Fellow _____ MD

Print Name of Attending / Fellow _____ MD# _____

Pharmacy Use Only:
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Patient Name: _____ Patient Identification #: _____