DATE TO BE GIVEN: _______ CYCLE: _______ REGIMEN/PROTOCOL: Liposomal Doxorubicin (Every 28 days)

PRIMARY DIAGNOSIS: Ovarian Cancer □ Other*: __________

* When selecting other diagnosis please provide protocol

ALLERGIES/REACTIONS:

Goal of Chemotherapy: □ Curative □ Palliative □ Neoadjuvant □ Adjuvant

MD to indicate which weight to use: □ Actual □ Ideal □ Adjusted

HEIGHT (cm): ACTUAL WEIGHT (kg): IDEAL WEIGHT (kg): ADJUSTED WEIGHT (kg):

and BSA (m²): and BSA (m²): and BSA (m²):

Dosing calculations to be completed by Pharmacist:

<table>
<thead>
<tr>
<th>CHEMOTHERAPY MEDICATION ORDERS</th>
<th>DOSE (mg/m²)</th>
<th>BSA (m²)</th>
<th>DOSE TO BE GIVEN</th>
<th>ROUTE</th>
<th>INFUSE OVER</th>
<th>DATE(S) AND FREQUENCY</th>
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<tbody>
<tr>
<td>Liposomal Doxorubicin</td>
<td>□ 40 mg/m²</td>
<td>X</td>
<td>=</td>
<td>IV</td>
<td>Initial rate 1 mg/minute or 60 minutes (whichever is longer), then over 60 minutes</td>
<td>Every 28 days</td>
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<tr>
<td></td>
<td>□ 50 mg/m²</td>
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HYDRATION ORDERS

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<tr>
<th>HYDRATION ORDERS</th>
<th>HYDRATION SOLUTION</th>
<th>ADDITIVES</th>
<th>RATE</th>
<th>DURATION</th>
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<td>BEFORE CHEMOTHERAPY</td>
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<td>DURING CHEMOTHERAPY</td>
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<td>AFTER CHEMOTHERAPY</td>
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DOSE MODIFICATION (MD TO BE NOTIFIED IF ANY OF THE FOLLOWING OCCUR):

- Absolute Neutrophil Count (ANC) less than 1000
- Platelets less than 100,000

Physician initial: ____________________________
PHARMACY TO MANAGE ANTIEMETICS

**ANTIEMETIC ORDERS/DRUG NAME** | **DOSE** | **ROUTE** | **TIMING**
--- | --- | --- | ---
Dexamethasone | 12 mg | PO | 30 minutes pre-chemo (Day 1)
☐ Dexamethasone (optional for potential delayed nausea/vomiting) | 8 mg | PO | Daily (Days 2-3)
Lorazepam | 0.5-1 mg | PO | 30 minutes pre-chemo times 1 dose PRN anxiety

Outpatient Prescription(s): *(for outpatients or early discharge)*

**TESTS:**
☐ MUGA Scan
☐ ECG
Other: ___________________________

**LABS – PRIOR TO START OF EACH CHEMO CYCLE:** CBC with differential, CMP, Magnesium, CA-125

**LABS – WEEKLY:** CBC with differential

**LABS – 3-4 WEEKS AFTER LAST CYCLE:** CBC with differential
☐ Urine Output: If urine output is less than ________ give ________________ times ________ days
☐ Nurse May Initiate CVAD Management Per Nursing Protocol #910.00
☐ Nurse May Utilize Local Anesthetic For CVAD Access Per Nursing Protocol #788
☐ Nurse May Initiate IV Catheter Care, Outpatient Physician Order #858
☐ For Infusion Reactions Initiate Drug Related Hypersensitivity Physician Order #774

**MEDICATIONS:**
☒ Pegfilgrastim (Neulasta) 6 mg subcutaneously on Day 2
☐ Other: ___________________________

**NOTE:** These orders should be reviewed by the attending physician, appropriately modified for the individual patient, dated and signed below.

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<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>PHARMACIST’S SIGNATURE</th>
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Another brand of drug, identical in form and content, may be dispensed unless checked. ☐