Adult Outpatient Chemotherapy Order Form (page 1 of 1)

Diagnosis / Indications: Breast Cancer
Regimen: AC (Dose Dense) - Q14DAYS

Patient Height: ________________ cm
Weight: Actual _________ kg  Ideal: _________ kg  Used: _________ kg

Body Surface Area: Actual: _________  Ideal: _________  Used: _________


Begin Therapy  Day #1 (______/______/______)

Chemotherapy:

<table>
<thead>
<tr>
<th>DRUG (Oral or injectable)</th>
<th>PROTOCOL DOSAGE (Per m² or Per kg)</th>
<th>PATIENT’S DOSE</th>
<th>ROUTE / FREQUENCY</th>
<th>GIVE ON DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxorubicin</td>
<td>60 mg/m²</td>
<td></td>
<td>IV</td>
<td>Day 1</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>600 mg/m²</td>
<td></td>
<td>IV</td>
<td>Day 1</td>
</tr>
<tr>
<td>Filgrastim</td>
<td>5 mcg/kg/day</td>
<td></td>
<td>Subcutaneously</td>
<td>Days 3 - 10</td>
</tr>
<tr>
<td>Pegfilgrastim</td>
<td>6 mg</td>
<td></td>
<td>Subcutaneously</td>
<td>Day 2</td>
</tr>
</tbody>
</table>

Fluid / Volume: minimal volume □ EF on ______=_______%  Flow Rate or Infusion Time: 15 minutes
Fluid / Volume: 250 mL NS  Flow Rate or Infusion Time: 30 - 60 minutes

Follow-up appt.: ___________________________ with labs ____________________________

Specific Administration Instructions/Requirements:
1. 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
2. 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:
1. Aprepitant 125 mg PO x 1  (Patient’s own medication)
2. Dexamethasone 12 mg IV x 1
3. Ondansetron 8 mg IV x 1
4. PRN Medications (please check appropriate meds):
   □ 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):
1. Aprepitant 80 mg PO days 2 and 3  (#2)
2. Dexamethasone 8 mg PO every AM Days 2, 3 and 4  (#3)
   □ 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:
084937-1

Patient Name: ___________________________  Patient Identification #: ___________________________