(Place Patient Identification Sticker Here)

Methodist Le Bonheur Healthcare

## Physician Orders ADULT

# Order Set: AC ( Adriamycin/Cytoxan)

**Diagnosis : Breast Cancer**

| | | | |
|---|---|---|---|
| Height:_____cm | Weight:_____kg | Cycle: | Of : |
| Actual BSA: m2 | Treatment BSA: m2 | Day/Wk: | Freq: q21days |
| **Allergies:** | [ ] No known allergies | | |
| [ ]Medication allergy(s): | | | |
| [ ] Latex allergy | [ ]Other: | | |

| | | |
|---|---|---|
| **Patient Care** | | |
| [ ] | Nursing Communication | T;N, Do not exceed a treatment BSA of m2 |
| [ ] | Nursing Communication | T;N, May hold hydration during chemotherapy infusion |
| [ ] | Nursing Communication | T;N, Verify patient has had MUGA or ECHO to r/o cardiac dysfunction prior to chemotherapy |
| **Continuous Infusions** | | |
| **Pre Hydration** | | |
| [ ] | Normal Saline | 1,000 mL , IV, mL/ hr |
| **Medications** | | |
| **CHEMOTHERAPY** | | |

| | Drug( generic) & solution ( optional) | Intended Dose | Actual Dose | Route, Infusion, Frequency and total doses |
|---|---|---|---|---|
| [X] | **DOXOrubicin** | **60 mg/m$^2$** | | **IV Push, Push over 5 min, Once on DAY 1** |
| [X] | **cyclophosphamide** | **600 mg/m$^2$** | | **IV Piggyback, Infuse over 60 min, Once on DAY 1** |

| | | |
|---|---|---|
| **Acute Emesis Prophylaxis ( may undergo therapeutic interchange)** | | |
| **NOTE: Administer initial doses at least 30-60 minutes prior to chemotherapy** | | |
| [X] | ondansetron | 16 mg, Injection, IV Piggyback, once, on DAY 1 |
| [X] | dexamethasone | 12 mg, Tab, PO, once, on DAY 1 |
| [X] | dexamethasone | 12 mg, Injection, IV Push, once, on DAY 1 , Comment : if unable to take PO |
| [X] | prochlorperazine | 10 mg, Tab, PO, q6h, PRN Nausea/Vomiting |
| [X] | prochlorperazine | 10 mg, Injection, IV Push, q6h, PRN Nausea/Vomiting , Comment : if unable to take PO |
| [X] | aprepitant | 125 mg, Tab, PO, once, on DAY 1 |
| [X] | aprepitant | 80 mg, Tab, PO, qDay, on DAY 2 and 3 |
| **Delayed Emesis Prophylaxis** | | |
| **NOTE: Start on Day ____** | | |
| [ ] | dexamethasone | 8 mg, Tab, PO, bid, for 2 days Comment: Day 1 and 2 of delayed emesis prophylaxis |
| [ ] | dexamethasone | 4 mg, Tab, PO, bid, for 2 days, Comment: Day 3 and 4 of delayed emesis prophylaxis |
| [ ] | ondansetron | Dose: mg, Tab, PO, Frequency: , Duration: |
| [ ] | metoclopramide | Dose: mg, Tab, PO, Frequency: , Duration: |
| [ ] | prochlorperazine | Dose: mg, Tab, PO, Frequency: , Duration: |
| **Consults/Notifications** | | |
| [ ] | Notify Physician- Once | T;N, Who: , For: if BSA exceeds 2 m$^2$ |

**Date** **Time** **Physician's Signature** **MD Number**