

Provis Patient No.									

MEDICATION ORDER FORM

Pegylated Liposomal Doxorubicin (Caelyx)									
Patient's Surname Giver	n Name & Initials		Date of Birth						
			//						
Referring MD/Oncologist									
Height: cm Dose F	Reduction? Yes □	No 🗆							
Weight:kg	n:								
BSA: m ² Cycle:									
Pre-Medications (No prophylactic anti-emetics usually necessary) Prochlorperazine 10 mg IV/ PO □ Other□									
45 minutes prior to pegylated liposomal doxorubicin: Dexamethasone 20 mg IV in 50 mL NS over 15 minutes 30 minutes prior to pegylated liposomal doxorubicin: Dyphenhydramine 50 mg IV and Ranitidine 50 mg IV in 50 mL NS over 20 minutes Chemotherapy: Pegylated liposomal doxorubicin 40 mg/m2 or 30 mg/m2 (circle one) x BSA									
	ng IV in 250 mL D		(======						
In Cycle 1: infuse over at least 1 hour (maximum rate 1mg/minute). For Cycle ≥2 and no previous reaction: infuse over 1 hour. If previous reaction: infuse over at least 1 hour and no faster than 1 mg/minute. Scheduled Frequency Repeat every 4-5 weeks									
Physician's Signature (Referring Oncologist)									
		/ /	/						
Signature of Provis Physician		/dd	/						
Repeat Order: Each cycle requires a new medication order.									
Fax completed form to: 416-532-3635									