



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: LYFLU

DOCTOR'S ORDERS			Ht _____ cm	Wt _____ kg	BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form					
DATE:	To be given:	Cycle #:			
Date of Previous Cycle: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, platelets day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, and Creatinine Clearance greater than 70 mL/min Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____					
CHEMOTHERAPY:					
Standard Dose:					
Oral Fludarabine 40 mg/m²/day x BSA = _____ mg PO daily for 5 consecutive days . Round dose to nearest 10 mg. Do not break, chew or crush tablets.					
OR					
Dose Modification Required:					
Oral Fludarabine 32 mg/m²/day x BSA = _____ mg PO daily for 3 consecutive days . Round dose to nearest 10 mg. Do not break, chew or crush tablets.					
OR					
Standard Dose:					
IV Fludarabine 25 mg/m²/day x BSA = _____ mg IV in 50 to 100 mL NS over 20 to 30 minutes daily for 5 days .					
OR					
Dose Modification Required:					
IV Fludarabine 20 mg/m²/day x BSA = _____ mg IV in 50 to 100 mL NS over 20 to 30 minutes daily for 3 days .					
RETURN APPOINTMENT ORDERS					
For Oral Use:					
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____.					
<input type="checkbox"/> Last Cycle. Return in _____ week(s).					
For IV use:					
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____. Book chemo x 5 or 3 days (circle one). (Match to dose duration above)					
<input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC & Diff, platelets, creatinine prior to each cycle.					
<input type="checkbox"/> Other tests:					
<input type="checkbox"/> Consults:					
<input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:				SIGNATURE:	
				UC:	