



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](http://www.bccancer.bc.ca) and according to acceptable standards of care

PROTOCOL CODE: BRAVT7

**DOCTOR'S ORDERS**

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

**REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form**

**DATE:** \_\_\_\_\_ **To be given:** \_\_\_\_\_ **Cycle #:** \_\_\_\_\_

Date of Previous Cycle: \_\_\_\_\_

Delay Treatment \_\_\_\_\_ week(s)

**CBC & Diff, platelets** day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than 90 x 10<sup>9</sup>/L**

Dose modification for:  **Hematology**  **Other Toxicity** \_\_\_\_\_

**Proceed with treatment based on blood work from** \_\_\_\_\_

**PREMEDICATIONS:**

**45 minutes prior to Paclitaxel:**

**Dexamethasone 10 mg** IV in 50 mL NS over 15 minutes.

**30 minutes prior to Paclitaxel:**

**Diphenhydramine 25 mg** IV and **Ranitidine 50 mg** IV in 50 mL NS over 20 minutes.

(compatible up to 3 hours when mixed in a bag)

No pre-medication required.

**Other:** \_\_\_\_\_

**\*\*Have Hypersensitivity Reaction Tray and Protocol Available\*\***

**CHEMOTHERAPY:**

**Paclitaxel 80 mg/m<sup>2</sup>** x BSA = \_\_\_\_\_ mg

**Dose Modification:** \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

IV in 250 mL (use non-PVC bag) NS over 1 hour once weekly x 4 weeks. (Use non PVC tubing with in-line filter.)

**DOSE MODIFICATION IF REQUIRED ON WEEK 2, 3 OR 4:**

**Paclitaxel** \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

IV in 250 mL (use non-PVC bag) NS over 1 hour once weekly on week(s) \_\_\_\_\_.

(Use non PVC tubing with in-line filter.)

**RETURN APPOINTMENT ORDERS**

Return in **four** weeks for Doctor and Cycle \_\_\_\_\_. Book chemo weekly x 4 weeks.

Last Cycle. Return in \_\_\_\_\_ weeks.

**CBC & Diff, platelets** prior to each treatment

If clinically indicated:  **Bilirubin**  **AST**

**Other tests:**

**Consults:**

**See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

UC: \_\_\_\_\_