BC Cancer Agency
CARE & RESEARCH

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: BRLAACD

Class II Drug Indication for use:
☐ Locally Advanced breast cancer
☐ Inflammatory breast cancer
For other indications, an "Undesignated Indications Request Form" must be completed and approved prior to treatment.

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:

☐ Delay Treatment _____ week(s)
☐ **CBC & Diff, Platelets** day of treatment
May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than 90 x 10^9/L**
Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

Ondansetron 8 mg PO prior to treatment
Dexamethasone 8 mg or **12 mg** (circle one) PO prior to treatment
For Docetaxel Cycles: **Dexamethasone 8 mg** PO bid for 3 days starting one day prior to docetaxel. Patient must receive 3 doses prior to treatment.
Optional: Frozen gloves starting 15 minutes before docetaxel infusion until 15 minutes after end of docetaxel infusion; gloves should be changed after 45 minutes of wearing.
☐ **Other:**

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

CHEMOTHERAPY:

Doxorubicin 60 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push

Cyclophosphamide 600 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour

OR

Docetaxel 100 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL NS (non-PVC bag) over 1 hour (Use non-PVC tubing)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Last Cycle. Return in _____weeks.

CBC & Diff, Platelets prior to each cycle
Prior to Cycle 5: Bilirubin, AST, ALT, Alk Phos
If clinically indicated:
☐ **Tot. Prot** ☐ **Albumin** ☐ **Bilirubin** ☐ **GGT** ☐ **Alk Phos.**
☐ **AST** ☐ **LDH** ☐ **ALT** ☐ **Creatinine** ☐ **MUGA Scan** ☐ **Echocardiogram**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:
UC: