



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: **UBRAJACTW**

A BCCA "Compassionate Access Program" 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: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, platelets day of treatment May proceed with doses as written if within 96h (for AC) or 24h (for paclitaxel) ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than 90 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> 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 AC treatment Dexamethasone 8 mg or 12 mg (circle one) PO prior to AC treatment OR 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 hrs when mixed in bag) <input type="checkbox"/> No pre-medication required (see protocol for guidelines) <input type="checkbox"/> Other: _____					
Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 5 to 8					
CHEMOTHERAPY: Doxorubicin 60 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV push Cyclophosphamide 600 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour OR Paclitaxel 80 mg/m² OR _____ mg/m ² (circle one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____% = _____ mg/m ² x BSA = _____ mg IV in 250 mL (non-PVC bag) NS over 1 hour once weekly x 3 weeks (use non-PVC tubing with in-line filter.)					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ (Book chemo room weekly x 3 for cycles 5-8)					
<input type="checkbox"/> Last Cycle. Return in _____ week(s)					
CBC & Diff, Platelets prior to each treatment Prior to Cycle #5: Bilirubin, ALT, AST If clinically indicated: <input type="checkbox"/> Creatinine <input type="checkbox"/> AST <input type="checkbox"/> ALT <input type="checkbox"/> Bilirubin <input type="checkbox"/> Muga <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:			SIGNATURE:		
			UC:		