



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: UHNAVPD

A BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment.

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

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, Creatinine** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than 100 x 10⁹/L, Creatinine Clearance greater than or equal to 60 mL/minute**

Dose modification for: **Hematology** **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

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

Dexamethasone 8 mg PO bid for 3 days starting one day prior to each administration of Docetaxel

A minimum of 3 doses of Dexamethasone pre-treatment are required

Ondansetron 8 mg PO 30 minutes prior to treatment

Optional: Aprepitant 125 mg PO 30 minutes prior to treatment, then 80 mg daily for 2 days after treatment

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.

HYDRATION:

Prehydrate with 1000 mL NS over 60 minutes

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

CHEMOTHERAPY:

Docetaxel 75 mg/m² x BSA = _____ mg

Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 250 to 500 mL (non-PVC bag) NS over 1 hour (use non-PVC tubing)

Cisplatin 75 mg/m² x BSA = _____ mg

Dose Modification: _____% = _____ mg/m² x BSA = _____ mg

IV in 500 mL NS with potassium chloride 20 mEq, magnesium sulphate 1 g, Mannitol 30 g over 1 hour

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____

Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, Serum Creatinine prior to each cycle

Prior to Cycle 4 and if clinically indicated: **AST** **Bili**

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: