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: UGIAVTZCAP

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:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets, Creatinine, Bilirubin, AST, Alk Phos** day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than 50 mL/min, AST less than 5 x ULN**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

Capecitabine 750 mg/m^2 x BSA x (_____%) = _____mg PO bid with food **Days 1 - 14**

(Total daily dose = 1500 mg/m^2/day) (Round dose to nearest 150 mg)

Temozolomide 200 mg/m^2 or _____ **mg/m^2**x BSA x (_____%) = _____mg PO daily on an empty stomach (30-60 minutes before a meal or 2 hours after a meal) **Days 10 - 14**

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets, Creatinine, Bilirubin, AST, Alk Phos prior to each cycle

☐ **INR** weekly ☐ **INR** prior to each cycle

If clinically indicated: ☐ **Electrolytes** ☐ **Magnesium** ☐ **Calcium** ☐ **Glucose**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: