PROTOCOL CODE: BRAJACTW

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** day of treatment

May proceed with doses as written for AC portion if labs done within 96 h: **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 90 x 10^9/L**

May proceed with doses as written for weekly paclitaxel portion if labs done within 24 h: **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to AC treatment

and **select** ONE of the following:

☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment
☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to AC treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes 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 in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ No pre-medication required (see protocol for guidelines)

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 5 to 8****

CHEMOTHERAPY:

DOXOrubicin 60 mg/m² x BSA = _____mg

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

IV push

cyclophosphamide 600 mg/m² x BSA =_____mg

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

IV in 100 to 250 mL NS over 20 minutes to 1 hour

OR

PACLitaxel ☐ **80 mg/m²** OR ☐ **_____ mg/m²** (select one) x BSA = _____ mg

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

IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.2 micron in-line filter)

DOSE MODIFICATION IF REQUIRED ON SUBSEQUENT DAYS (Cycle 5-8):

PACLitaxel 80 mg/m² x BSA = _____ mg

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

IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour on days _____ (use non-DEHP tubing with 0.2 micron in-line filter)

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____ (Book chemo room weekly x 3 for cycles 5-8)

☐ Book filgrastim (G-CSF) SC teaching and first dose on Cycle ____ Day ____

☐ Last Cycle. Return in _____week(s) after last treatment.

CBC & Diff prior to each treatment

Prior to **Cycle #5**: **total bilirubin, ALT**

If clinically indicated: ☐ **creatinine** ☐ **ALT** ☐ **total bilirubin**

☐ **MUGA scan** ☐ **echocardiogram**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: