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 day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9/L$,
Platelets greater than $90 \times 10^9/L$

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 (circle 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 on Day 1, then 80 mg PO daily on Day 2 and 3
- ☐ ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment

As needed antiemetics:
- ☐ prochlorperazine 10 mg PO prn
- ☐ metoclopramide 10 mg PO prn
- OR

45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in NS 50 mL over 15 minutes
30 Minutes Prior to PACLitaxel: diphenhydramine 50 mg IV and ranitidine 50 mg IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag)
- ☐ 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 NS 100 to 250 mL over 20 minutes to 1 hour
- OR
- PACLitaxel 175 mg/m² OR 150 mg/m² (circle one) x BSA = _________mg
  - Dose Modification: ________% = _________ mg/m² x BSA = _________ mg
  - IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.22 micron or smaller in-line filter.)

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle __________
☐ Last Cycle. Return in __________________ week(s)

CBC & Diff, Platelets prior to each cycle
- ☐ Bilirubin, ALT, prior to next treatment.
  If clinically indicated: ☐ Creatinine ☐ ALT ☐ Bilirubin ☐ Muga Scan ☐ Echocardiogram
- ☐ Other tests:
- ☐ Consults:
- ☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE: SIGNATURE:

UC: