PROTOCOL CODE: BRAJDC

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 x 10⁹/L,
Platelets greater than or equal to 90 x 10⁹/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 ____________________________

ondansetron 8 mg PO prior to treatment
dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel; patient must receive 3 doses prior to treatment

Optional: 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.

☐ Other:

** Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY:  Administer cyclophosphamide first to reduce hypersensitivity response to DOCEtaxel

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

DOCEtaxel 75 mg/m² x BSA = _________mg

☐ Dose Modification: ________% = _________ mg/m² x BSA = _________ mg

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

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle___________
☐ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day_______
☐ Last Cycle. Return in ______ week(s).

CBC & Diff, Platelets prior to each cycle

If clinically indicated and prior to 1st Cycle (Creatinine, Billirubin, Alk Phos, ALT)

☐ Billirubin  ☐ Creatinine  ☐ Tot. Prot  ☐ Albumin  ☐ GGT
☐ LDH  ☐ ALT  ☐ Alk Phos  ☐ BUN

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  SIGNATURE:  UC: