Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

**PROTOCOL CODE: BRAVGEMT**

**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 Day 1 if within 24 hours ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$

May proceed with doses as written Day 8 if within 24 hours ANC greater than or equal to $1.2 \times 10^9/L$, Platelets greater than or equal to $75 \times 10^9/L$

Dose modification for:  ☐ Hematology  ☐ Other Toxicity_________________________

Proceed with treatment based on blood work from_________________________

**PREMEDICATIONS:**

45 minutes prior to PACLitaxel:

dexamethasone 20 mg IV in 50 mL NS over 15 minutes.

30 minutes prior to PACLitaxel:

diphenhydrAMINE 50 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes. (compatible up to 3 hours when mixed in a bag)

☐ Other:

**CHEMOTHERAPY:**

PACLitaxel $175 \text{ mg/m}^2 \times \text{BSA} = \text{__________mg}$

☐ Dose Modification: $\% = \text{__________mg/m}^2 \times \text{BSA} = \text{__________mg}$

IV in 250 to 500 mL NS (use non-DEHP bag) over 3 hours Day 1 only. (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

gemcitabine $1250 \text{ mg/m}^2 \times \text{BSA} = \text{__________mg}$

☐ Dose Modification: $\% = \text{__________mg/m}^2 \times \text{BSA} = \text{__________mg}$

IV in 250 mL NS over 30 minutes Day 1 and 8

**RETURN APPOINTMENT ORDERS**

☐ Return in three weeks for Doctor and Cycle ______. Book chemo room Day 1 & 8

☐ Last Cycle. Return in ____________ weeks.

CBC & Diff, Platelets prior to each treatment

If clinically indicated:  ☐ Bilirubin  ☐ ALT  ☐ Creatinine

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

SIGNATURE:

UC: