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:
45 minutes prior to PACLitaxel: dexemathasone 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 bag)
ondansetron 8 mg PO 30 minutes prior to CARBOplatin

**Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY: (Note – continued over 2 pages)

CYCLE #1 DAY 1

trastuzumab 8 mg/kg x _______ kg =_________ mg IV in NS 250 mL over 1 hour 30 minutes; observe for 1 hour post infusion

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
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<tr>
<td>trastuzumab</td>
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CYCLE #1 DAY 2

PACLitaxel 175 mg/m² x BSA =_________ mg

☐ Dose Modification: _______ mg/m² x BSA = ___________ mg

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

CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) =_________ mg

☐ Dose Modification: _______ % = ________ mg

IV in 250 mL NS over 30 minutes

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 2 to 6***

DOCTOR’S SIGNATURE: SIGNATURE: UC:
**DATE:** To be given: Cycle #:

### CHEMOTHERAPY: (Continued)

*** SEE PAGE 1 FOR CHEMOTHERAPY CYCLE 1 ***

**OR**

#### CYCLE # 2

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PACLitaxel 175 mg/m² x BSA = ________ mg

- Dose Modification: ______ mg/m² x BSA = ________ mg
- IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours (use Non DEHP tubing with 0.22 micron or smaller in-line filter)

CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) = ________ mg

- Dose Modification: ______% = ________ mg
- IV in 250 mL NS over 30 minutes

**OR**

#### CYCLE # 3 to 6

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PACLitaxel 175 mg/m² x BSA = ________ mg

- Dose Modification: ______ mg/m² x BSA = ________ mg
- IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours (use Non DEHP tubing with 0.22 micron or smaller in-line filter)

CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) = ________ mg

- Dose Modification: ______% = ________ mg
- IV in 250 mL NS over 30 minutes

acetaminophen 325 mg – 650 mg PO PRN for headache and rigors

### DOCTOR'S SIGNATURE:

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### RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle ________.
- Last Cycle. Return in ___________ weeks.

**CBC & Diff, Platelets, Creatinine** prior to each cycle

If clinically indicated:  
- □ Total Bilirubin  
- □ ALT

- □ Consults:

- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**