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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

**PROTOCOL CODE: BRAVTW**

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

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 24 hours ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L

Dose modification for: □ Hematology □ Other Toxicity__________________________

Proceed with treatment based on blood work from____________________

**PREMEDICATIONS:**

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 and ranitidine 50 mg IV in 50 mL NS over 20 minutes.
  (compatible up to 3 hours when mixed in a bag)
- □ No pre-medication required.
- □ Other:

  **“Have Hypersensitivity Reaction Tray and Protocol Available”**

**CHEMOTHERAPY:**

PACLitaxel 90 mg/m² x BSA = _________mg
- □ Dose Modification: ______ mg/m² x BSA = _________ mg

IV in 100 to 250 mL (use non-DEHP bag) NS over 1 hour once weekly x 3 weeks, then 1 week off.
(Use non DEHP tubing with 0.22 micron or smaller in-line filter)

**DOSE MODIFICATION IF REQUIRED ON WEEK 2 or 3:**

PACLitaxel _________ mg/m² x BSA = _________ mg

IV in 100 to 250 mL (use non- DEHP bag) NS over 1 hour once weekly on week(s) ____________.
(Use non DEHP tubing with 0.22 micron or smaller in-line filter)

**RETURN APPOINTMENT ORDERS**

- □ Return in **four** weeks for Doctor and Cycle ______. Book chemo weekly x 3 weeks.
- □ Last Cycle. Return in ______ weeks from last treatment.

CBC & Diff, platelets prior to each treatment

If clinically indicated: □ Bilirubin □ ALT □ Alk Phos

- □ Other tests:
- □ Consults:
- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**