### PROTOCOL CODE: BRAVTW

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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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 1.5 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 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 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: