PROTOCOL CODE: BRLAACD

**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht.</th>
<th>cm</th>
<th>Wt.</th>
<th>kg</th>
<th>BSA</th>
<th>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 96 hours **ANC greater than or equal to 1.5 x 10⁹/L**, **Platelets greater than 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 AC treatment
- **dexamethasone** 8 mg or 12 mg (circle one) PO prior to AC treatment
- **aprepitant** 125 mg PO pre-chemotherapy on Day 1 and 80 mg PO post-chemotherapy once daily on Days 2 and 3
- **prochlorperazine** 10 mg PO prn
- **metoclopramide** 10 mg PO prn

**For DOCEtaxel Cycles:**

- **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:**

**CHEMOTHERAPY:**

- **Doxorubicin** 60 mg/m² x BSA = __________ mg
  - **Dose Modification:** _______% = ______ mg/m² x BSA = __________ mg
  - **IV push**

- **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**

**OR**

- **DOCEtaxel** 100 mg/m² x BSA = __________ mg
  - **Dose Modification:** _______% = ______ mg/m² x BSA = __________ mg
  - **IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour (Use non-DEHP tubing)**

**RETURN APPOINTMENT ORDERS**

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

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

**Prior to Cycle 5:** Bilirubin, AST, ALT, Alk Phos

If clinically indicated:

- Tot. Prot  □ Albumin  □ Bilirubin  □ GGT  □ Alk Phos.
- AST  □ LDH  □ ALT  □ Creatinine  □ MUGA Scan  □ Echocardiogram
- Other tests:

- **Consults:**

- **See general orders sheet for additional requests.**

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**