



Provincial Health Services Authority

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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: BRLAPNACG

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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:

Number of PACLitaxel doses completed to date: _____

- Delay treatment _____ week(s)
- CBC & Diff, platelets** day of treatment

May proceed with doses as written for PACLitaxel NAB portion if labs done within 72 h: **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 for AC portion if labs done within 72 h: **ANC greater than or equal to $1.0 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$**

Dose modification for: **Hematology** **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

For cycles with DOXOrubicin and cyclophosphamide:

dexamethasone **8 mg** or **12 mg** (select one) PO 30 to 60 minutes prior to AC treatment and **select ONE** of the following:

<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to AC treatment ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to AC treatment

Other:

CHEMOTHERAPY: (Note – continued over 2 pages)

CYCLE # _____

PACLitaxel NAB (ABRAXANE) 260 mg/m² x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

***** SEE PAGE 2 FOR AC CHEMOTHERAPY CYCLES *****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

PROTOCOL CODE: BRLAPNACG

DOCTOR'S ORDERS

DATE:

To be given:

Cycle #:

CHEMOTHERAPY: (Continued)

OR

CYCLE # _____

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 NS 100 to 250 mL over 20 minutes to 1 hour

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____. (For PACLitaxel NAB treatment and first cycle of AC)

Return in **two** weeks for Doctor and Cycle _____. (For AC treatment)

Book filgrastim (G-CSF) SC teaching and first dose on Cycle: ____ Day: ____

Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets prior to each cycle

If clinically indicated: creatinine ALT bilirubin GGT

alkaline phosphatase urea

MUGA Echocardiogram

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: