PROTOCOL CODE: BRLAPNAC

DOCTOR'S ORDERS

Ht _____cm Wt _____kg BSA _____m^2

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 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L**

May proceed with doses as written for AC portion if labs done within 72 h: **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 90 x 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:

☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment
☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to AC treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment
☐	**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/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 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: BRLAPNAC

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 100 to 250 mL NS over 20 minutes to 1 hour

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____week(s) after last treatment.

CBC & Diff, Platelets prior to each treatment

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: