**PROTOCOL CODE: BRLATACG**

<table>
<thead>
<tr>
<th>DOCTOR'S ORDERS</th>
<th>Ht________cm Wt________kg BSA________m²</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

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<th>Date of Previous Cycle:</th>
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- [ ] 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 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:** Patient to take own supply. RN/Pharmacist to confirm ________________.

- 45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in NS 50 mL over 15 minutes
- 30 Minutes Prior to PACLitaxel: diphenhydrAMINE 50 mg IV and ranitidine 50 mg IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag)
- [ ] Other:
  - [ ] 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-chemo on Day 1 and 80 mg PO post-chemo once daily on Days 2 and 3
  - [ ] Prochlorperazine 10 mg PO prn
  - [ ] Metoclopramide 10 mg PO prn

**CHEMOTHERAPY:**

- PACLitaxel 175 mg/m² x BSA = ___________ mg
  
  - [ ] Dose Modification: _________% = _________ mg/m² x BSA = ___________ mg
  
  IV in NS 500 mL (non-DEHP bag) over 3 hours (Use non-DEHP tubing with **0.22 micron or smaller in-line filter**)
- 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 **two** weeks for Doctor and Cycle ____________
- [ ] Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day ____________
- [ ] Last Cycle. Return in ____________ week(s)

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

If clinically indicated: [ ] Creatinine [ ] AST [ ] Bilirubin [ ] Muga Scan [ ] Echocardiogram

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

**DOCTOR'S SIGNATURE:**

| SIGNATURE: |
|------------------|-----------------------------------------|

| UC: | UC: |

BC Cancer Agency Provincial Preprinted Order BRLATACG
Created: 01 Nov 2014 Revised: 1 Aug 2016