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:

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

May proceed with doses as written if within 24h (for paclitaxel) or 96h (AC) ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 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 ___________________________.

- 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 hrs when mixed in bag)
- No pre-medication required (see protocol for guidelines)
- Other:

OR

Select ONE of the following routine antiemetics regimens:

- ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment
dexamethasone 8 mg or 12 mg (circle one) 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
dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to AC treatment

As needed antiemetics:
- prochlorperazine 10 mg PO prn
- metoclopramide 10 mg PO prn

**Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4**

CHEMOTHERAPY: (Note – continued over 2 pages)

- CYCLE #__________ (Cycle 1-4)

PACLitaxel 80 mg/m² OR _________ mg/m² (circle one) x BSA = _________ mg

- Dose Modification: _________ % = _________ mg/m² x BSA = _________ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8 ***

DOCTOR’S SIGNATURE: SIGNATURE:

UC:
# DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</table>

## CHEMOTHERAPY continued

- **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 ____________ (Book chemo room weekly x 3 for cycles 1-4, book chemo room every 3 weeks for AC cycles 5-8, cycle 5 to start week 13)

- Last Cycle. Return in ________________ week(s) after last treatment.

## CBC & Diff, Platelets prior to each treatment

If clinically indicated:
- [ ] Creatinine
- [ ] ALT
- [ ] Bilirubin
- [ ] Muga
- [ ] Echocardiogram

## Other tests:

- [ ] Consults:

See general orders sheet for additional requests.

## DOCTOR’S SIGNATURE:

**SIGNATURE:**

**UC:**