PROTOCOL CODE: GIPGEMABR

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/Week #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & diff, platelets** day of treatment

- May proceed with doses day 1 as written, if within 48 hours **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 day 8 and day 15 **(if day 8 was given)** as written, if within 48 hours **ANC greater than or equal to 1 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L**
- **Refer to protocol for day 15 bloodwork parameters if day 8 was omitted.**

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 treatment
☐ **dexamethasone 12 mg** PO prior to treatment
☐ **Other:**

**** Have Hypersensitivity Tray and Protocol Available****

CHEMOTHERAPY:

PACLitaxel NAB (ABRAXANE) ☐ **125 mg/m^2** or ☐ **100 mg/m^2** or ☐ **75 mg/m^2** ***(select one)*** x BSA = _____mg
IV over 30 minutes weekly x 3 weeks on Days 1, 8 & 15 (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

gemcitabine ☐ **1000 mg/m^2** or ☐ **800 mg/m^2** or ☐ **600 mg/m^2** ***(select one)*** x BSA = _____ mg
IV in 250 mL NS over 30 minutes weekly x 3 weeks on Days 1, 8 & 15

DOSE MODIFICATION IF REQUIRED ON SUBSEQUENT DAYS:
PACLitaxel NAB (ABRAXANE) ☐ **100 mg/m^2 or** ☐ **75 mg/m^2** ***(select one)*** x BSA = _____mg
IV over 30 minutes on Days _____ (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

gemcitabine ☐ **800 mg/m^2** or ☐ **600 mg/m^2** ***(select one)*** x BSA= _____ mg
IV in 250 mL NS over 30 minutes on Days_____

☐ Book chemo weekly x _____ weeks
☐ Return in **four** or _____weeks for Doctor and Cycle _____.
☐ Return for Physician only in _____ week(s).
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets, BILI, ALT, Alk Phos, creatinine prior to each cycle (day 1)
CBC & diff, platelets prior to days 8 and 15.
☐ **CEA** ☐ **CA 19-9**
☐ **Imaging Study:**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: