**PROTOCOL CODE: GIPGEMABR**

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht (cm)</th>
<th>Wt (kg)</th>
<th>BSA (m²)</th>
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**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 10⁹/L, platelets greater than or equal to 100 x 10⁹/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 10⁹/L, platelets greater than or equal to 75 x 10⁹/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/m² or ☐ 100 mg/m² or ☐ 75 mg/m² (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/m² or ☐ 800 mg/m² or ☐ 600 mg/m² (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/m² or ☐ 75 mg/m² (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/m² or ☐ 600 mg/m² (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)

**CEA** ☐ CA 19-9

**Imaging Study:**

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

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**