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** 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, total bilirubin less than or equal to 1.5 x ULN, AST or ALT less than or equal to 10 x ULN**
- 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 1.0 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:**

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**_____

☐ Return in **four** or _____weeks for Doctor and Cycle _____. Book chemo on Days 1, 8, and 15
☐ Return for Physician only in _____ week(s).
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle (Day 1)
CBC & Diff prior to Days 8 and 15
If clinically indicated:
☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT**
☐ **sodium** ☐ **potassium** ☐ **random glucose** ☐ **HbA1c**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: