



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: **GUPCABA**

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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 #:** _____ **(every 3 weeks = 1 cycle)**

Date of Previous Cycle: _____

- Delay treatment _____ week(s)
- CBC & Diff, platelets** on day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $90 \times 10^9/L$**

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 cabazitaxel:

dexamethasone 8 mg IV in NS 50 mL over 15 minutes

30 minutes prior to cabazitaxel:

diphenhydramine 50 mg IV and **ranitidine 50 mg IV** in NS 50 mL over 20 minutes

ondansetron 8 mg PO 30 minutes prior to cabazitaxel

Other

CHEMOTHERAPY:

cabazitaxel 25 mg/m^2 x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m^2 x BSA = _____ mg

IV in 250 mL NS (non-DEHP bag) over 60 minutes (use non-DEHP tubing with 0.2 in-line filter)

predniSONE 10 mg PO once daily or **5 mg PO** twice daily. Mitte: _____ days

***Alternate** steroid dosing option:

dexamethasone 1.5 mg PO once daily. Mitte: _____ days

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____

Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets prior to each cycle.

PSA every 3 weeks

If clinically indicated: **Creatinine** **Bilirubin**

Other tests:

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: