PROTOCOL CODE: GUTEM

DOCTOR'S ORDERS

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form
One cycle consists of 4 weeks of once weekly temsirolimus

DATE: **To be given:** **Cycle #: weeks_____**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 75 x 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 _____.

diphenhydrAMINE 25 mg or 50 mg (circle one) IV in 50 mL NS over 20 minutes prior to temsirolimus

☐ **Other:**

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

CHEMOTHERAPY:

temsirolimus 25 mg
☐ Dose Modification: 20 mg or 15 mg (circle one)
IV in 250 mL NS (non-DEHP bag) over 30 minutes weekly x _____weeks.
(use non-DEHP tubing with in-line filter)

RETURN APPOINTMENT ORDERS

☐ Return in _____ week(s) for Doctor and Cycle _____ week_____.
Book weekly treatment x_____weeks

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets prior to **each treatment**

Sodium, Potassium, Creatinine, BUN, Glucose, Calcium, Phosphorus, ALT, LDH, Total Bili, Alk. Phos., Total Cholesterol, Triglycerides prior to **each cycle (every 4 weeks)**

If clinically indicated: ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT** ☐ **INR/PTT**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: