PROTOCOL CODE: KSVB

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 #:

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 _____ x 10⁹/L, Platelets greater than or equal to _____ x 10⁹/L or
- [ ] ANC greater than 1 x 10⁹/L, Platelets greater than 74 x 10⁹/L (vinBLAS)tine Only

Dose modification for: [ ] Hematology [ ] Other Toxicity

Proceed with treatment based on blood work from ____________________________.

PREMEDICATIONS: [ ] Patient to take own supply. RN/Pharmacist to confirm ____________________________.

- [ ] Prochlorperazine 10 mg PO pre-chemotherapy PRN OR
- [ ] Metoclopramide 10 mg PO pre-chemotherapy PRN
- [ ] Hydrocortisone 100 mg IV pre-Bleomycin

CHEMOTHERAPY:

**DAY 1:**

- [ ] vinBLAS (circle one) 6 mg, 10 mg, or _______ mg
  - [ ] Dose Modification: (_______%) = ________mg
  - IV in 50 mL NS over 15 minutes

If Neutropenia, omit vinBLAS

Substitute bleomycin 10 units/m² x BSA = _______ units

- [ ] Dose Modification: (_______%) = ________units/m² x BSA = ________units
- IV in 50 mL NS over at least 10 minutes

**DAY 8:**

- [ ] vinCRIStine 1 mg
  - [ ] Dose Modification: (_______%) = ________mg
  - IV in 50 mL NS over 15 mins.

If neurological dysfunction, omit vinCRIStine

Substitute bleomycin 10 units/m² x BSA = _______ units

- [ ] Dose Modification: (_______%) = ________units/m² x BSA = ________units
- IV in 50 mL NS over at least 10 minutes

OR

- methotrexate 25 mg/m² x BSA = _______ mg
  - [ ] Dose Modification: _______ % = _______ mg/m² x BSA = _______ mg
  - IV push

RETURN APPOINTMENT ORDERS

- [ ] Return in _______ weeks for Doctor and Cycle ________ ((Book Chemo Day 1 and 8)
- [ ] Last Cycle. Return in _______ week(s).

CBC prior to each cycle (if vinBLAS OR Methotrexate being used)

CR (only required if using Bleomycin and Methotrexate)

If clinically indicated:

- [ ] Tot. Prot
- [ ] Albumin
- [ ] Bilirubin
- [ ] GGT
- [ ] Alk Phos.
- [ ] AST
- [ ] LDH
- [ ] ALT
- [ ] BUN
- [ ] Creatinine

Other tests:

- [ ] Consults:

See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: SIGNATURE:

UC: