PROTOCOL CODE: LKPEGIFN

**DOCTOR’S ORDERS**

| Ht________cm | Wt________kg | BSA________m² |

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Week(s)# ______</th>
</tr>
</thead>
</table>

- [ ] Delay treatment _____ week(s)
- [ ] CBC & Diff, platelet day of treatment

May proceed with doses as written if within 72 hours ANC **greater than or equal to** 0.75 x 10⁹/L,
Platelets **greater than or equal to** 50 x 10⁹/L

Dose modification for:  
- [ ] Hematology  
- [ ] Other Toxicity:

Proceed with treatment based on blood work from __________________________

**TREATMENT:**

- peginterferon alfa-2a (PEGASYS) ____ mcg subcutaneous injection every week for ____ weeks
- peginterferon alfa-2a (PEGASYS) ____ mcg subcutaneous injection every week for ____ weeks

Mitte: _________ dose  Repeat x _________

**RETURN APPOINTMENT ORDERS**

- [ ] Return in _______weeks) for Doctor.

**First 3 months:**
- [ ] CBC and Diff, AST, ALT, Alk Phos. every month

**After 3 months:**
- [ ] CBC and Diff, AST, ALT, Alk Phos. every ____ month(s)
- [ ] Other tests:
- [ ] Consults:  
  - [ ] PFC  
  - [ ] Others:

See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

| SIGNATURE: |
| UC: |