**PROTOCOL CODE: LKPEGIFN**

## DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

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

**DATE:**

<table>
<thead>
<tr>
<th>To be given:</th>
<th>Week(s)#</th>
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</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, ALT, Alk Phos. every month

### After 3 months:

- □ CBC and Diff, ALT, Alk Phos. every ____ month(s)
- □ Other tests:

- □ Consults:
  - □ PFC
  - □ Others:

- □ See general orders sheet for additional requests.

## DOCTOR’S SIGNATURE:

**SIGNATURE:**

**UC:**