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: LUAVDOC**

For other indications or treatment beyond 6 cycles, a BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

## DOCTOR'S ORDERS

**Ht**__________**cm** **Wt**__________**kg** **BSA**__________**$m^2$**

**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 96 hours **ANC greater than or equal to 1.5 x $10^9$/L, Platelets greater than or equal to 100 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 ________________________.

**dexamethasone 8 mg** PO bid for 3 days starting one day prior to each treatment; **a minimum of 3 doses of dexamethasone pre-treatment are required**

**Optional: Frozen gloves** starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion;

gloves should be changed after 45 minutes of wearing.

☐ **Other:**

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

**CHEMOTHERAPY:**

**DOCEtaxel 75 mg/$m^2$** x BSA = __________ mg

☐ Dose Modification: ________% = ________ mg/$m^2$ x BSA = __________ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (Use non-DEHP tubing)

## RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _________

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

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

Prior to **Cycle 4**: **Bilirubin, ALT, Alk Phos, LDH**

If clinically indicated: ☐ **ALT** ☐ **Bili** ☐ **Alk Phos** ☐ **LDH**

☐ **Other tests:**

☐ **Consults:**

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

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**