### 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>Cycle #:</th>
</tr>
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</table>

**Date of Previous Cycle:**

- □ Delay treatment ______ week(s)
- □ CBC & Diff, Platelets on day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to** 0.25 x 10⁹/L, **Platelets greater than or equal to** 25 x 10⁹/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 50 mg PO prior to treatment
- acetaminophen 650 mg PO prior to treatment
- predniSONE 10 mg PO 15 to 30 minutes prior to alemtuzumab for the first two weeks.

- □ Other:

- Have Hypersensitivity Reaction Tray and Protocol Available

**TREATMENT:**

- **Cycle_______:**
  - **Monday:** alemtuzumab 3 mg / 10 mg / 30 mg (circle one) in 100 mL NS IV over 2 hours
  - **Wednesday:** alemtuzumab 3 mg / 10 mg / 30 mg (circle one) in 100 mL NS IV over 2 hours
  - **Friday:** alemtuzumab 3 mg / 10 mg / 30 mg (circle one) in 100 mL NS IV over 2 hours

- **OR**
  - **Cycle_______:**
    - **Monday:** alemtuzumab 3 mg / 10 mg / 30 mg (circle one) SC
    - **Wednesday:** alemtuzumab 3 mg / 10 mg / 30 mg (circle one) SC
    - **Friday:** alemtuzumab 3 mg / 10 mg / 30 mg (circle one) SC

Observe for 60 minutes post administration; refer to protocol for monitoring. (see #3 under **Precautions** of protocol)

**RETURN APPOINTMENT ORDERS**

- □ Return in **one week** for Doctor and **week** __________ book chemo Monday, Wednesday and Friday.
- □ Last Cycle. Return in _____ week(s).

**Weekly each Monday:** CBC & Diff, Platelets, CMV-DNA by PCR

- □ Other tests:
- □ Consults:
- □ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**