**PROTOCOL CODE: LYCDA**

**DOCTOR’S ORDERS**

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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:

First cycle: Proceed with full dose as ordered, regardless of blood counts. Adjust dose for Creatinine Clearance only, if required.

If a subsequent cycle is given: May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, Creatinine Clearance greater than 70 mL/min.**

Dose modification for:  

□ Creatinine Clearance  

□ Other Toxicity _________________________

Proceed with treatment based on blood work from __________________________

**CHEMOTHERAPY: (Choose one ONLY)**

If **Creatinine Clearance is greater than 70 mL/min:**

**cladribine 0.14 mg/kg/day = _________ mg/day**

- IV in 500 mL NS over 2 hours daily on **Days 1 to 5.**

**cladribine 0.14 mg/kg/day = _________ mg/day SC** daily on **Days 1 to 5.**

Dose Modification if **Creatinine Clearance 30-70 mL/min:**

**cladribine 0.14 mg/kg/day = _________ mg/day**

- IV in 500 mL NS over 2 hours daily on **Days 1 to 3.**

**cladribine 0.14 mg/kg/day = _________ mg/day SC** daily on **Days 1 to 3.**

*cladribine is provided as 1 mg/mL solution. SC administration requires several syringes to be administered therefore, IV route may be preferred.

**RETURN APPOINTMENT ORDERS**

Return in ______ week(s).

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

SIGNATURE:

UC: