

PROTOCOL CODE: LYCVPPABO
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DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²
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** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to $0.8 \times 10^9/L$**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____

ondansetron 8 mg PO prior to treatment.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO prior to treatment.

hydrocortisone 100 mg IV prior to bleomycin in 50 to 100 mL NS over 15 to 30 minutes prior to bleomycin on **day 8**.

☐ **hydrocortisone 100 mg** IV prior to etoposide

☐ **diphenhydramine 50 mg** IV prior to etoposide

☐ **Other:** _____

****Have Hypersensitivity Reaction Tray and Protocol Available****
CHEMOTHERAPY:
DAY 1:
vinBLASTine 6 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 50 mL NS over 15 minutes

cyclophosphamide 600 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour.

predniSONE 45 mg/m² x BSA = _____ mg PO daily x 14 days in AM. (Round to nearest 25 mg)

procarbazine 100 mg/m² x BSA = _____ mg PO daily x 7 days. (Round to nearest 50 mg)

DAY 8:
DOXOrubicin 35 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV push.

vinCRISTine 1.4 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV in 50 mL NS over 15 minutes

bleomycin 10 units/m² x BSA = _____ units IV in 50 mL NS over 15 minutes.

***** SEE PAGE 2 FOR ADDITIONAL ORDERS *****
DOCTOR'S SIGNATURE: _____

SIGNATURE: _____

UC: _____



Provincial Health Services Authority

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

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DOCTOR'S ORDERS	
DATE:	To be given: Cycle #:
<input type="checkbox"/> If bilirubin greater than 85 micromol/L Omit DOXOrubicin. Substitute cyclophosphamide 525 mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 20 minutes to 1 hour on Day 8.	
<input type="checkbox"/> If cardiac dysfunction Omit DOXOrubicin. Substitute etoposide 35 mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS (non-DEHP bag) over 45 minutes on day 8 (Use Non-DEHP tubing with 0.2 micron in-line filter) AND etoposide 70 mg/m ² x BSA = _____ mg PO on days 9 and 10. (Round dose to nearest 50 mg)	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in four weeks for Doctor and Cycle # _____. Book Chemo on Days 1 and 8.	
<input type="checkbox"/> Last Cycle. Return in _____ week(s).	
CBC & Diff prior to each treatment. If clinically indicated: <input type="checkbox"/> total bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> HBV viral load <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: