



Provincial Health Services Authority

PROTOCOL CODE: LYMBEX

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/terms-of-use and according to acceptable standards of care.

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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:				
May proceed with doses as written if within 24 hours (for first treatment) or 7 days (for subsequent prescriptions) ANC greater than or equal to 0.8×10^9 /L, fasting triglycerides less than or equal to 3.5 mmol/L and ALT and bilirubin less than or equal to 3 times the upper limit of normal range.				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity: _____				
TREATMENT:				
bexarotene <input type="checkbox"/> 300 mg/m ² /day OR <input type="checkbox"/> 400 mg/m ² /day OR <input type="checkbox"/> 200 mg/m ² /day (select one) = _____ mg PO once daily. (round off to nearest 75 mg)				
Mitte: _____ months				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in eight weeks for Doctor.				
<input type="checkbox"/> Return in _____ week(s).				
CBC & Diff, ALT, total bilirubin , fasting triglycerides , TSH and T4 every two months.				
ALT, total bilirubin and fasting triglycerides weekly after initiating treatment (until stabilization – usually first 2-4 weeks)				
If clinically indicated: <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:		