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: CNTEMOZMD

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** day of treatment

May proceed with doses as written on Day 1 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, ALT less than or equal to 2.5 x ULN and total bilirubin less than 25 micromol/L**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

temozolomide ☐ **50 mg/m^2** or ☐ **35 mg/m^2** (select one) x BSA = _____mg PO daily at bedtime x 28 days

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

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

CBC & Diff, ALT, total bilirubin, random glucose prior to each cycle

If clinically indicated: ☐ **electrolytes** ☐ **magnesium** ☐ **calcium** ☐ **creatinine**

☐ **CT** or ☐ **MRI head** (select one) every 2 cycles (i.e., prior to Cycles 3, 5, etc.)

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: