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: CNTEMOZ

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, Platelets** day of treatment

May proceed with doses as written on Day 1 if within 24 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, Bilirubin less than 25 micromol/L and Day 22 ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 50 x 10^9/L**

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

Proceed with treatment based on blood work from _____

CHEMOTHERAPY:

temozolomide ☐ **150 mg/m^2** or☐ _____ **mg/m^2** *(select one)* x BSA = _____mg PO daily at bedtime x 5 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 and Diff prior to each cycle and Day 22

ALT, total bilirubin, random glucose prior to each cycle (Day 1 only)

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

☐ **CT** or ☐ **MRI head** *(select one)* every ☐ 2 or ☐ 3 cycles *(select one)*

☐ **Other tests:**

☐ **Consults:**

☐ **Change MRP to** _____

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: