PROTOCOL CODE: SANAHDMAP

Cycles 5 and 6

DOXOrubicin

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 #:** _____ **Week 1**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff** day of treatment

May proceed with DOXOrubicin as written if within 48 hours **ANC greater than or equal to 0.75 x 10^9/L, platelets greater than or equal to 75 x 10^9/L**

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

Proceed with treatment based on blood work from_____

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

ondansetron 8 mg PO (or ☐ IV) 30 minutes prior to treatment on Days 1 and 2

dexamethasone 8 mg PO (or ☐ IV) 30 minutes prior to treatment on Days 1 and 2

☐ **Other:**

TREATMENT:

DOXOrubicin 37.5 mg/m^2 x BSA =_____mg

☐ Dose modification: _____% =_____ mg/m^2 x BSA = _____ mg

IV push on **Days 1 and 2**

RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and Cycle _____, Week 3 methotrexate. Admit for Day 1 (plan for 4 day admission)	
CBC & Diff, sodium, potassium, creatinine, calcium, magnesium, albumin, total bilirubin, alkaline phosphatase, ALT, LDH, GGT prior to Day 1 of each treatment ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**