



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/terms-of-use](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**PROTOCOL CODE: HNLADCF**

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|   |                     |                 |             |             |                          |
|---|---------------------|-----------------|-------------|-------------|--------------------------|
| <b>DOCTOR'S ORDERS</b>  |                     |                 | Ht _____ cm | Wt _____ kg | BSA _____ m <sup>2</sup> |
| <b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form   |                     |                 |             |             |                          |
| <b>DATE:</b>  | <b>To be given:</b> | <b>Cycle #:</b> |             |             |                          |
| Date of Previous Cycle:   |                     |                 |             |             |                          |
| <input type="checkbox"/> Delay treatment _____ week(s)<br><input type="checkbox"/> <b>CBC &amp; Diff, platelets, creatinine, ALT, alkaline phosphatase</b> day of treatment   |                     |                 |             |             |                          |
| May proceed with doses as written if within 24 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, platelets greater than or equal to 100 x 10<sup>9</sup>/L, creatinine clearance greater than or equal to 60 mL/minute, alkaline phosphatase less than 2.5 x ULN, and AST or ALT less than 1.5 x ULN</b>  |                     |                 |             |             |                          |
| Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____<br>Proceed with treatment based on blood work from _____   |                     |                 |             |             |                          |
| <b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.<br><b>dexamethasone 8 mg</b> PO bid for 3 days starting one day prior to treatment<br><b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to treatment<br><b>aprepitant 125 mg</b> PO 30 to 60 minutes prior to treatment<br><b>filgrastim 5 mcg/kg/day daily SC</b> (rounded to nearest vial size: 300 mcg or 480 mcg) <b>highly recommended.</b> Start <b>Day 5</b> after chemo & treat through post-nadir ANC recovery (7 days)<br><b>Optional: Frozen gloves</b> starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.<br><input type="checkbox"/> <b>Other:</b> |                     |                 |             |             |                          |
| <b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>   |                     |                 |             |             |                          |
| <b>PRE-HYDRATION:</b>   |                     |                 |             |             |                          |
| 1000 mL NS over 1 hour pre-CISplatin  |                     |                 |             |             |                          |
| <b>CHEMOTHERAPY:</b>  |                     |                 |             |             |                          |
| <b>DOCEtaxel 75 mg/m<sup>2</sup> x BSA = _____ mg</b>   |                     |                 |             |             |                          |
| <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg<br>IV in NS 250 to 500 mL (non-DEHP bag) over 1 hour (use non-DEHP tubing)   |                     |                 |             |             |                          |
| <b>CISplatin 75 mg/m<sup>2</sup> x BSA = _____ mg</b>   |                     |                 |             |             |                          |
| <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg<br>IV in NS 500 mL with potassium chloride 20 mEq, magnesium sulfate 1 g, mannitol 30 g over one hour  |                     |                 |             |             |                          |
| <b>fluorouracil 750 mg/m<sup>2</sup>/day x BSA = _____ mg/day for 5 days (total dose = _____ mg over 120 h)</b>   |                     |                 |             |             |                          |
| <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg/day for 5 days (total dose = _____ mg over 120 h)<br>IV in D5W to a total volume of 240 mL by continuous infusion at 2 mL/h via Baxter LV2 infusor   |                     |                 |             |             |                          |
| <b>DOCTOR'S SIGNATURE:</b>  |                     |                 |             |             | <b>SIGNATURE:</b>        |
|   |                     |                 |             |             | <b>UC:</b>               |



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|   |                   |
|---|-------------------|
| <b>DATE:</b>  |                   |
| <b>RETURN APPOINTMENT ORDERS</b>  |                   |
| <input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____<br><input type="checkbox"/> Last Cycle. Return in _____ week(s).   |                   |
| <b>CBC &amp; Diff, platelets, creatinine, ALT, alkaline phosphatase</b> prior to each cycle<br><input type="checkbox"/> <b>Other tests:</b><br><input type="checkbox"/> <b>Book for PICC assessment/insertion per Centre process</b><br><input type="checkbox"/> <b>Book for IVAD insertion per Centre process</b><br><input type="checkbox"/> <b>Weekly PICC dressing change and assessment for infection or thrombosis during chemo appointment</b><br><input type="checkbox"/> <b>Consults:</b><br><input type="checkbox"/> <b>See general orders sheet for additional requests.</b> |                   |
| <b>DOCTOR'S SIGNATURE:</b>  | <b>SIGNATURE:</b> |
|   | <b>UC:</b>        |