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: SAAVTW



## 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 if within 48 hours **ANC greater than or equal to 1.0 x $10^9$/L, Platelets greater than or equal to 100 x $10^9$/L**
Dose modification for: ☐ **Hematology** ☐ **Other Toxicity**_____
**Proceed with treatment based on blood work from** _____

**PREMEDICATIONS:**

**45 minutes prior to PACLitaxel:**

**dexamethasone 10 mg** IV in 50 mL NS over 15 minutes.

**30 minutes prior to PACLitaxel:**

**diphenhydrAMINE 25 mg** IV in 50 mL NS over 15 minutes and **famotidine 20 mg** IV in 100 mL NS over 15 minutes (Y-site compatible).
☐ No pre-medication required.
☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

**CHEMOTHERAPY:**

**PACLitaxel 80 mg/$m^2$** x BSA = _____mg

☐ Dose Modification: ☐ **70 mg/$m^2$ or** ☐ **60 mg/$m^2$ (select one)** x BSA = _____ mg

IV in 100 to 500 mL (use non-DEHP bag) NS over 1 hour once weekly x 3 weeks, then 1 week off.
(Use non DEHP tubing with 0.2 micron in-line filter)

**DOSE MODIFICATION IF REQUIRED ON WEEK 2 or 3:**

**PACLitaxel** ☐ **70 mg/$m^2$ or** ☐ **60 mg/$m^2$ (select one)** x BSA = _____mg

IV in 100 to 500 mL (use non- DEHP bag) NS over 1 hour once weekly on week(s) _____.
(Use non DEHP tubing with 0.2 micron in-line filter)

**RETURN APPOINTMENT ORDERS**

| | |
|---|---|
| ☐ Return in **four** weeks for Doctor and Cycle _____. Book chemo weekly x 3 weeks.<br>☐ Last Cycle. Return in _____weeks from last treatment. | |
| **CBC & Diff, platelets** prior to each treatment<br>If clinically indicated: ☐ **Bilirubin** ☐ **ALT** ☐ **Alk Phos** ☐ **Creatinine**<br>☐ **Other tests:**<br>☐ **Consults:**<br>☐ **See general orders sheet for additional requests.** | |
| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br>**UC:** |