

PROTOCOL CODE: BRAJACT

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:				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, platelets greater than or equal to 90 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.				
dexamethasone 8 mg or 12 mg (select one) PO 30 to 60 minutes prior to AC treatment and select ONE of the following:				
<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to AC treatment ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to AC treatment			
OR				
45 Minutes Prior to PACLitaxel: dexamethasone 20 mg IV in NS 50 mL over 15 minutes 30 Minutes Prior to PACLitaxel: diphenhydramine 50 mg IV in NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible)				
<input type="checkbox"/> Other:				
Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 5 to 8				
TREATMENT:				
DOXOrubicin 60 mg/m² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV push				
cyclophosphamide 600 mg/m² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in NS 100 to 250 mL over 20 minutes to 1 hour				
OR				
PACLitaxel 175 mg/m² OR 150 mg/m² (select one) x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in NS 250 to 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter.)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Book filgrastim (G-CSF) SC teaching and first dose on Cycle ____ Day ____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff prior to each cycle <input type="checkbox"/> total bilirubin, ALT , prior to next treatment. If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> ALT <input type="checkbox"/> total bilirubin <input type="checkbox"/> MUGA scan <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other tests: _____ <input type="checkbox"/> Consults: _____ <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: