

**PROTOCOL CODE: BRAVCAP (PO)**

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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) <input type="checkbox"/> <b>CBC &amp; Diff, creatinine</b> day of treatment		
May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 75 x 10<sup>9</sup>/L, creatinine clearance greater than 50 mL/min.</b>		
Dose modification for: <input type="checkbox"/> <b>Age /ECOG</b> <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____		
<b>Proceed with treatment based on blood work from</b> _____		
<b>TREATMENT:</b>		
<b>Capecitabine</b> <input type="checkbox"/> 1000 mg/m <sup>2</sup> or <input type="checkbox"/> 1250 mg/m <sup>2</sup> (select one) x BSA x ( _____ %) = _____ mg PO BID x 14 days on Days 1 to 14.		
<b>Pharmacist to select dose band per last page of PPO. Complete table below (please print)</b>		
<b>Drug</b>	<b>Dose Band (mg)</b>	<b>Pharmacist Initial and Date</b>
capecitabine		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____		
<input type="checkbox"/> Last Cycle. Return in _____ week(s).		
<b>CBC &amp; Diff, creatinine</b> prior to each cycle  If clinically indicated: <input type="checkbox"/> <b>total protein</b> <input type="checkbox"/> <b>albumin</b> <input type="checkbox"/> <b>total bilirubin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>alkaline phosphatase</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>urea</b> <input type="checkbox"/> <b>CA 15-3</b>  <input type="checkbox"/> <b>Other tests:</b>  <input type="checkbox"/> <b>Weekly nursing assessment for (specify concern):</b> _____  <input type="checkbox"/> <b>Consults:</b>  <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>

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**CAPECITABINE BANDING TABLE**

Ordered Dose (mg)		Rounded dose (mg)	Number of Tablets Per Dose	
From:	To:		150 mg	500 mg
226	375	300	2	
376	475	450	3	
476	575	500		1
576	725	650	1	1
726	900	800	2	1
901	1075	1000		2
1076	1225	1150	1	2
1226	1400	1300	2	2
1401	1575	1500		3
1576	1725	1650	1	3
1726	1900	1800	2	3
1901	2075	2000		4
2076	2225	2150	1	4
2226	2400	2300	2	4
2401	2575	2500		5
2576	2725	2650	1	5
2726	2900	2800	2	5
2901	3075	3000		6
3076	3225	3150	1	6
3226	3400	3300	2	6
3401	3575	3500		7
3576	3725	3650	1	7
3726	3900	3800	2	7