

PROTOCOL CODE: BRLATACG

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 72 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 100 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 _____. 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) OR dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 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				
<input type="checkbox"/>	Other: _____				
Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4					
TREATMENT:					
PACLitaxel 175 mg/m² 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)					
OR					
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					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in two weeks for Doctor and Cycle _____ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)					
CBC & Diff prior to each cycle If clinically indicated: <input type="checkbox"/> creatinine <input type="checkbox"/> ALT <input type="checkbox"/> total bilirubin <input type="checkbox"/> MUGA <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: