

PROTOCOL CODE: BRLATWAC

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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 for weekly paclitaxel portion if labs done within 24 h: ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 90 x 10⁹/L May proceed with doses as written for AC portion if labs done within 96 h: 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 _____. 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 NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible) <input type="checkbox"/> No pre-medication required (see protocol for guidelines) 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: (Note – continued over 2 pages)					
<input type="checkbox"/> CYCLE # _____ (Cycle 1-4)					
PACLitaxel <input type="checkbox"/> 80 mg/m² OR <input type="checkbox"/> _____ mg/m² (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour once weekly x 3 weeks (use non-DEHP tubing with 0.2 micron in-line filter)					
*** SEE PAGE 2 FOR CHEMOTHERAPY CYCLES 5 TO 8 ***					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

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DOCTOR'S ORDERS	
DATE:	To be given:
Cycle #:	
TREATMENT: continued	
<input type="checkbox"/> CYCLE # _____ (Cycle 5-8)	
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 100 to 250 mL NS over 20 minutes to 1 hour	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ (Book chemo room weekly x 3 for cycles 1-4, book chemo room every 3 weeks for AC cycles 5-8, cycle 5 to start week 13)	
<input type="checkbox"/> Book filgrastim (G-CSF) SC teaching and first dose on Cycle ____ Day ____	
<input type="checkbox"/> Last Cycle. Return in _____ week(s) after last treatment.	
CBC & Diff prior to each treatment 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: