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: GIGAVTW

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** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to 1.5 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****

TREATMENT:

PACLitaxel 80 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____ mg/m^2 x BSA = _____ mg
IV in 100 to 500 mL (use non-DEHP bag) NS over 60 minutes on **Days 1, 8 and 15.**
(Use non DEHP tubing with 0.2 micron in-line filter)

DOSE MODIFICATION IF REQUIRED ON SUBSEQUENT DAYS:

PACLitaxel _____ **mg/m^2** x BSA = _____mg
IV in 100 to 500 mL (use non- DEHP bag) NS over 60 minutes on **Day(s)** _____
(Use non DEHP tubing with 0.2 micron in-line filter)

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____. Book treatment on Days 1, 8 and 15.
☐ Last Cycle. Return in _____weeks from last treatment.

Prior to Day 1 of each Cycle**: CBC & Diff**, **creatinine, total bilirubin, ALT**
Prior to Days 8 and 15 of each Cycle: **CBC & Diff**

If clinically indicated: ☐ **CEA** ☐ **CA 19-9** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **weekly INR** ☐ **ECG**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: