PROTOCOL CODE: BRAJDC

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, Platelets** day of treatment
May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 90 x 10^9/L**
Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

ondansetron 8 mg PO prior to treatment
dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel; patient must receive 3 doses prior to treatment
Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.
☐ **Other:**

**** Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY: **Administer cyclophosphamide first to reduce hypersensitivity response to DOCEtaxel**

cyclophosphamide 600 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour

DOCEtaxel 75 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day_____
☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets prior to each cycle
If clinically indicated and **prior to 1st Cycle (Creatinine, Bilirubin, Alk Phos, ALT)**
☐ **Bilirubin** ☐ **Creatinine** ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT**
☐ **LDH** ☐ **ALT** ☐ **Alk Phos** ☐ **BUN**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: