# 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:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff, platelets** day of treatment
May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.0 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:** 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** ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to AC treatment
and **select** ONE of the following:

| | |
|---|---|
| ☐ | **ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment |
| ☐ | **aprepitant 125 mg** PO 30 to 60 minutes prior to AC treatment<br>**ondansetron 8 mg** PO 30 to 60 minutes prior to AC treatment |
| ☐ | **netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to AC treatment |

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4****

**CHEMOTHERAPY:**

**PACLitaxel 175 mg/$m^2$** x BSA = _____ mg
☐ 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/$m^2$** x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/$m^2$ x BSA = _____ mg
IV push
**cyclophosphamide 600 mg/$m^2$** x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/$m^2$ x BSA = _____ mg
IV in NS 100 to 250 mL over 20 minutes to 1 hour

## RETURN APPOINTMENT ORDERS

☐ Return in **two** 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: ☐**Creatinine** ☐**ALT** ☐**Bilirubin** ☐**Muga Scan** ☐**Echocardiogram**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**
**UC:**