PROTOCOL CODE: GUPDOC

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 90 x 10^9/L** (for cycles 1 and 4, also if within 96 hours **total bilirubin less than or equal to ULN, alkaline phosphatase less than 2.5 x ULN (unless bone metastases), and AST and/or ALT less than or equal to 1.5 x ULN**)

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity: _____**

Proceed with treatment based on blood work from _____

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

dexamethasone 8 mg PO bid for 3 days, starting one day prior to treatment; **patient must receive a minimum of 3 doses pretreatment**

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:

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 one hour (use non-DEHP tubing)

predniSONE ☐ **10 mg** PO daily **or** ☐ **5 mg** PO bid

Mitte: 21 days OR _____ months

*Steroid Dosing Option:

dexamethasone 1.5 mg daily. Mitte: _____ days.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, platelets and PSA prior to each cycle

Prior to Cycle 4: **ALT, alkaline phosphatase, total bilirubin, LDH**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: