PROTOCOL CODE: KSLDO

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m²

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 72 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 75 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 _____.

☐ **prochlorperazine** 10 mg PO or ☐ **metoclopramide** 10 mg PO 30 to 60 minutes prior to treatment

If ***prior*** infusion reaction:

45 minutes prior to DOXOrubicin pegylated liposomal:

☐ **dexamethasone 20 mg** IV in 50 mL D5W over 15 minutes

30 minutes prior to DOXOrubicin pegylated liposomal:

☐ **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)

☐ Other:

CHEMOTHERAPY:

All lines to be primed with D5W

DOXOrubicin pegylated liposomal 20 mg/m² x BSA =_____ mg

☐ Dose Modification: (_____%) = _____mg/m² x BSA = _____mg

IV in 250 mL D5W over 1 h*

*In Cycle 1, infuse over at least 1 h (maximum 1mg/min). For subsequent doses and no prior reaction, infuse over 1 h

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____.

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

CBC and Diff, Platelets prior to each cycle

If clinically indicated:

☐ Tot. Prot ☐ Albumin ☐ Bilirubin ☐ GGT ☐ Alk Phos.

☐ LDH ☐ ALT ☐ BUN ☐ Creatinine

☐ **Other tests:** (ie: ECG, Echocardiogram, MUGA Scan) _____

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: