



Provincial Health Services Authority

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](http://www.bccancer.bc.ca) and according to acceptable standards of care

**PROTOCOL CODE: SAAVGEMD**

To continue beyond 6 cycles, a BC Cancer "Compassionate Access Program" request must be approved.

<b>DOCTOR'S ORDERS</b>		Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form				
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay Treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment				
May proceed with doses as written <b>Day 1</b> if within 24 hours <b>ANC greater than or equal to 0.9 x 10<sup>9</sup>/L and Platelets greater than or equal to 100 x 10<sup>9</sup>/L</b>				
May proceed with doses as written <b>Day 8</b> if within 24 hours <b>ANC greater than or equal to 1.4 x 10<sup>9</sup>/L and Platelets greater than or equal to 100 x 10<sup>9</sup>/L</b>				
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____				
<b>Proceed with treatment based on bloodwork from</b> _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____				
<b>dexamethasone 8 mg PO BID</b> for 3 days, starting one day prior to each DOCEtaxel treatment (i.e., starting on Day 7) Note: A minimum of 3 doses of dexamethasone pre-treatment is required.				
<b>ondansetron 8 mg PO 30 to 60 minutes</b> prior to treatment <b>on Day 8</b>				
<b>Optional:</b> <input type="checkbox"/> <b>prochlorperazine 10 mg PO</b> or <input type="checkbox"/> <b>metoclopramide 10 mg</b> (select one) PO prior to treatment <b>on Days 1 and 8</b>				
<b>Optional: Frozen gloves</b> starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.				
<input type="checkbox"/> <b>Other:</b> _____				
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>				
<b>CHEMOTHERAPY:</b>				
<b>DAY 1</b>				
<b>gemcitabine</b> <input type="checkbox"/> <b>900 mg/m<sup>2</sup></b> or <input type="checkbox"/> _____ <b>mg/m<sup>2</sup></b> (select one) x BSA = _____ <b>mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 mL NS at 10 mg/m <sup>2</sup> /min <b>(i.e., 900 mg/m<sup>2</sup> dose = 1 h 30 min, 750 mg/m<sup>2</sup> dose = 1 h 15 min)</b>				
<b>DAY 8</b>				
<b>gemcitabine</b> <input type="checkbox"/> <b>900 mg/m<sup>2</sup></b> or <input type="checkbox"/> _____ <b>mg/m<sup>2</sup></b> (select one) x BSA = _____ <b>mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 mL NS at 10 mg/m <sup>2</sup> /min <b>(i.e., 900 mg/m<sup>2</sup> dose = 1 h 30 min, 750 mg/m<sup>2</sup> dose = 1 h 15 min)</b>				
<b>DOCEtaxel 75 mg/m<sup>2</sup></b> x BSA = _____ <b>mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL NS (use non-DEHP bag) over 1 hour (Use non DEHP tubing)				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				<b>UC:</b>

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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book Chemo room Day 1 & 8. <input type="checkbox"/> Last Cycle. Return in _____ weeks.	
<p><b>CBC &amp; Diff, platelets</b> prior to each treatment (Day 1 and 8)</p> <p>Prior to <b>Cycle 4</b>: <b>total bilirubin</b>, LDH ALT, GGT, <b>alkaline phosphatase</b></p> <p>If clinically indicated:</p> <input type="checkbox"/> <b>total protein</b> <input type="checkbox"/> <b>albumin</b> <input type="checkbox"/> <b>total bilirubin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>alkaline phosphatase</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>urea</b> <input type="checkbox"/> <b>creatinine</b> <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>