PROTOCOL CODE: BRAJDAC

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 1.5x 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 30 to 60 minutes prior to treatment

☐ **aprepitant 125 mg** PO 30 to 60 minutes 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:** Patient to receive a prescription for **filgrastim** for days 3-10 of treatment.

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

CHEMOTHERAPY:

DOXOrubicin 50 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push

cyclophosphamide 500 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 NS (non-DEHP bag) 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).

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

DOCTOR'S SIGNATURE:

SIGNATURE:

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