PROTOCOL CODE: BRAJFECD

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 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 _____.
dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to FEC treatment
and **select** ONE of the following:

☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to FEC treatment
☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to FEC treatment **ondansetron 8 mg** PO 30 to 60 minutes prior to FEC treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to FEC treatment

For DOCEtaxel cycles: **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.
☐ **hydrocortisone 100 mg** IV PRN
☐ **Other:**

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

CHEMOTHERAPY:

epirubicin 100 mg/m^2 x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg
IV push

fluorouracil 500 mg/m^2 x BSA x =_____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

OR

DOCEtaxel 100 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 1 hour (use non-DEHP tubing)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Last Cycle. Return in _____ week(s).

CBC & Diff, Platelets prior to each cycle
Prior to **Cycle 4**: **Bilirubin, Alk Phos, ALT**
If clinically indicated: ☐ **Bilirubin** ☐ **Creatinine** ☐ **Tot. Prot** ☐ **Albumin**
☐ **GGT** ☐ **LDH** ☐ **ALT** ☐ **Alk Phos** ☐ **BUN** ☐ **Muga Scan**
☐ **Echocardiogram**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:
UC: