

**PROTOCOL CODE: BRLAACD**

<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> on day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 90 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 blood work from</b> _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.				
<b>dexamethasone</b> <input type="checkbox"/> <b>8 mg</b> or <input type="checkbox"/> <b>12 mg</b> (select one) PO 30 to 60 minutes prior to AC treatment and <b>select ONE</b> of the following:				
<input type="checkbox"/>	<b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/>	<b>aprepitant 125 mg</b> PO 30 to 60 minutes prior to AC treatment <b>ondansetron 8 mg</b> PO 30 to 60 minutes prior to AC treatment			
<input type="checkbox"/>	<b>netupitant-palonosetron 300 mg-0.5 mg</b> PO 30 to 60 minutes prior to AC treatment			
<b>For DOCEtaxel Cycles:</b> dexamethasone 8 mg PO bid for 3 days starting one day prior to DOCEtaxel; patient must receive 3 doses prior to treatment <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>DOXOrubicin 60 mg/m<sup>2</sup> x BSA = _____ mg</b>				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg				
IV push				
<b>cyclophosphamide 600 mg/m<sup>2</sup> x BSA = _____ mg</b>				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg				
IV in 100 to 250 mL NS over 20 minutes to 1 hour				
<b>OR</b>				
<b>DOCEtaxel 100 mg/m<sup>2</sup> x BSA = _____ mg</b>				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg				
IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour (Use non-DEHP tubing)				
<b>RETURN APPOINTMENT ORDERS</b>				
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Cycle. Return in _____ weeks.				
<b>CBC &amp; Diff, Platelets</b> prior to each cycle				
<b>Prior to Cycle 5:</b> Bilirubin, ALT, Alk Phos				
If clinically indicated:				
<input type="checkbox"/>	<input type="checkbox"/> Tot. Prot	<input type="checkbox"/> Albumin	<input type="checkbox"/> Bilirubin	<input type="checkbox"/> GGT
<input type="checkbox"/>	<input type="checkbox"/> LDH	<input type="checkbox"/> Creatinine	<input type="checkbox"/> MUGA Scan	<input type="checkbox"/> Alk Phos.
<input type="checkbox"/>	<input type="checkbox"/> ALT			
<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>