PROTOCOL CODE: BRLACPNACG

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:

Number of PACLitaxel doses completed to date: _____

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, platelets** day of treatment

For PACLitaxel NAB and CARBOplatin:
May proceed with doses as written if within 72 h **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L**

For DOXOrubicin and cyclophosphamide:
May proceed with doses as written if within 72 h **ANC greater than or equal to 1.0 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 treatment

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment, and **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

If additional antiemetic required:

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to treatment

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 1 to 4****

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE #_____**

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

CARBOplatin AUC ☐ **6 or** ☐ **5 or** ☐ **4** (select one) **x (GFR + 25)** = _____ mg

☐ Dose Modification: _____ % = _____ mg
IV in 100 to 250 mL NS over 30 minutes

***** SEE PAGE 2 FOR AC CHEMOTHERAPY CYCLES *****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

PROTOCOL CODE: BRLACPNACG

DOCTOR'S ORDERS

DATE: **To be given:** **Cycle #:**

CHEMOTHERAPY : (Continued)

OR

☐ **CYCLE #_____**

DOXOrubicin 60 mg/m² x BSA = _____mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV push

cyclophosphamide 600 mg/m² x BSA =_____mg
☐ Dose Modification: _____% = _____ mg/m² x BSA = _____ mg
IV in 100 to 250 mL NS over 20 minutes to 1 hour

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____. (For PACLitaxel NAB and CARBOplatin treatment, and first cycle of AC)

☐ Return in **two** weeks for Doctor and Cycle _____. (For AC treatment)

☐ Book filgrastim (G-CSF) SC teaching and first dose on Cycle: ___ Day: ___

☐ Last Cycle. Return in _____ week(s) after last treatment.

Cycles with PACLitaxel NAB and CARBOplatin:
CBC & Diff, Platelets, creatinine prior to each cycle.

Cycles with DOXOrubicin and cyclophosphamide:
CBC & Diff, Platelets prior to each cycle.

If clinically indicated: ☐ **ALT** ☐ **bilirubin** ☐ **GGT** ☐ **alkaline phosphatase**
☐ **urea** ☐ **creatinine**
☐ **MUGA** ☐ **Echocardiogram**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:
UC: