PROTOCOL CODE: LYTEM

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** 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, ALT less than or equal to 2.5 x ULN, total bilirubin less than 25 micromol/L** and if ordered, **creatinine less than or equal to 2 x ULN**

Dose modification for: ☐ **Hematology** ☐ **Hepatotoxicity** ☐ **Other Toxicity:** _____

Proceed with treatment based on blood work from _____

TREATMENT:

temozolomide ☐ **150 mg/m^2** or ☐ _____ **mg/m^2** *(select one)* x BSA = _____mg PO once daily x 5 days (Days 1 to 5)

(refer to Temozolomide Suggested Capsule Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, ALT, total bilirubin prior to each cycle

If clinically indicated:

☐ **creatinine** ☐ **sodium** ☐ **potassium** ☐ **magnesium** ☐ **calcium**

☐ **random glucose**

☐ **HBV viral load** every 3 months ☐ **HBsAg** every 3 months

☐ Other tests:

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: