

PROTOCOL CODE: GOSADG

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* For more than 6 cycles, a BC Cancer "Compassionate Access Program" request must be completed and approved

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: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets day of treatment May proceed with Day 1 doses as written if within 72 hours ANC greater than or equal to 1.0 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L. <i>If pre-Day 8 labwork has been ordered, may proceed with Day 8 doses as written if within 48 hours ANC greater than or equal to 0.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L.</i>					
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____					
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.					
dexamethasone 8 mg PO BID for 3 days (6 doses), starting one day prior to DOCEtaxel; patient must receive minimum of three doses pre-chemotherapy. No premedications on Day 8 unless otherwise specified.					
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.					
<input type="checkbox"/> Other: _____					
** Have Hypersensitivity Reaction Tray and Protocol Available **					
CHEMOTHERAPY:					
DOCEtaxel 80 mg/m² x BSA = _____ mg					
<input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg					
IV in 250 to 500 mL NS (non-DEHP bag) over 1 hour on Day 1 only (use non-DEHP tubing).					
gemcitabine 800 mg/m² x BSA = _____ mg					
<input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg					
IV in 250 mL NS over 30 minutes on Day 1 and Day 8					
DOSE MODIFICATION DAY 8:					
gemcitabine <input type="checkbox"/> 800 mg/m² or <input type="checkbox"/> _____ mg/m ² (select one) x _____ % = _____ mg/m ² x BSA = _____ mg					
IV in 250 mL NS over 30 minutes on Day 8					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

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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:		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in 3 weeks for Doctor and Cycle _____. Book chemo Day 1 and Day 8. <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, Platelets prior to Day 1 (all cycles) and prior to Day 8 (in cycle 1 only, unless specified below) <input type="checkbox"/> CBC & Diff, Platelets prior to Day 8. If clinically indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos. (prior to Day 1) <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:	SIGNATURE: UC:	