



# BC Cancer Agency

CARE & RESEARCH

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care.

PROTOCOL CODE: BRAJDC

## DOCTOR'S ORDERS

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

**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  $1.5 \times 10^9/L$ ,**

**Platelets greater than  $90 \times 10^9/L$**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** \_\_\_\_\_

Proceed with treatment based on blood work from \_\_\_\_\_

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm \_\_\_\_\_.

**ondansetron 8 mg** PO prior to treatment

**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.

☐ **Other:** \_\_\_\_\_

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

**CHEMOTHERAPY: Administer cyclophosphamide first to reduce hypersensitivity response to DOCEtaxel**

**cyclophosphamide  $600 \text{ mg/m}^2$**  x BSA = \_\_\_\_\_ mg

☐ Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_  $\text{mg/m}^2$  x BSA = \_\_\_\_\_ mg

IV in 100 to 250 mL NS over 20 minutes to 1 hour

**DOCEtaxel  $75 \text{ mg/m}^2$**  x BSA = \_\_\_\_\_ mg

☐ Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_  $\text{mg/m}^2$  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 \_\_\_\_\_

☐ **Post Cycle 1 only: Book filgrastim (G-CSF) SC teaching and first dose on Day** \_\_\_\_\_

☐ Last Cycle. Return in \_\_\_\_\_ week(s).

**CBC & Diff, Platelets** prior to each cycle

If clinically indicated and **prior to 1<sup>st</sup> Cycle (Creatinine, Bilirubin, Alk Phos, AST, ALT)**

☐ **Bilirubin** ☐ **Creatinine** ☐ **Tot. Prot** ☐ **Albumin** ☐ **GGT**

☐ **AST** ☐ **LDH** ☐ **ALT** ☐ **Alk Phos** ☐ **BUN**

☐ **Other tests:** \_\_\_\_\_

☐ **Consults:** \_\_\_\_\_

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

UC: \_\_\_\_\_