



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care

PROTOCOL CODE: BRAVTW

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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:	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 doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____				
Proceed with treatment based on blood work from _____				
PREMEDICATIONS:				
<u>45 minutes prior to PACLitaxel:</u>				
dexamethasone 10 mg IV in 50 mL NS over 15 minutes.				
<u>30 minutes prior to PACLitaxel:</u>				
diphenhydramine 25 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes. (compatible up to 3 hours when mixed in a bag)				
<input type="checkbox"/> No pre-medication required.				
<input type="checkbox"/> Other: _____				
Have Hypersensitivity Reaction Tray and Protocol Available				
CHEMOTHERAPY:				
PACLitaxel 90 mg/m² x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg				
IV in 250 mL (use non-DEHP bag) NS over 1 hour once weekly x 3 weeks, then 1 week off. (Use non DEHP tubing with 0.22 micron or smaller in-line filter)				
DOSE MODIFICATION IF REQUIRED ON WEEK 2 or 3:				
PACLitaxel _____ mg/m² x BSA = _____ mg				
IV in 250 mL (use non- DEHP bag) NS over 1 hour once weekly on week(s) _____. (Use non DEHP tubing with 0.22 micron or smaller in-line filter)				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____. Book chemo weekly x 3 weeks.				
<input type="checkbox"/> Last Cycle. Return in _____ weeks from last treatment.				
CBC & Diff, platelets prior to each treatment				
If clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> ALT <input type="checkbox"/> Alk Phos				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:		SIGNATURE:		
		UC:		