



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: BRAJACT

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>					
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>			
Date of Previous Cycle: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, platelets</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to <math>1.5 \times 10^9/L</math>, Platelets greater than <math>90 \times 10^9/L</math></b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ Proceed with treatment based on blood work from _____					
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>ondansetron 8 mg</b> PO prior to AC treatment <b>dexamethasone 8 mg or 12 mg</b> (circle one) PO prior to AC treatment <input type="checkbox"/> <b>aprepitant 125 mg</b> PO pre-chemotherapy on Day 1 and <b>80 mg</b> PO post-chemotherapy once daily on Days 2 and 3 <input type="checkbox"/> <b>prochlorperazine 10 mg</b> PO prn <input type="checkbox"/> <b>metoclopramide 10 mg</b> PO prn <b>OR</b> 45 Minutes Prior to PACLitaxel: <b>dexamethasone 20 mg</b> IV in NS 50 mL over 15 minutes 30 Minutes Prior to PACLitaxel: <b>diphenhydrAMINE 50 mg</b> IV and <b>ranitidine 50 mg</b> IV in NS 50 mL over 20 minutes (compatible up to 3 hrs when mixed in bag) <input type="checkbox"/> <b>Other:</b> _____					
<b>**Have Hypersensitivity Reaction Tray and Protocol Available for Cycles 5 to 8**</b>					
<b>CHEMOTHERAPY:</b> <b>DOXOrubicin 60 mg/m<sup>2</sup></b> x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV push <b>cyclophosphamide 600 mg/m<sup>2</sup></b> x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in NS 100 to 250 mL over 20 minutes to 1 hour <b>OR</b> <b>PACLitaxel 175 mg/m<sup>2</sup> OR 150 mg/m<sup>2</sup></b> (circle one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in NS 500 mL (non-DEHP bag) over 3 hours (use non-DEHP tubing with <b>0.22 micron or smaller</b> in-line filter.)					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s)					
<b>CBC &amp; Diff, Platelets</b> prior to each cycle <input type="checkbox"/> <b>Bilirubin, AST</b> , prior to next treatment. If clinically indicated: <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>Muga Scan</b> <input type="checkbox"/> <b>Echocardiogram</b> <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC: