

PROTOCOL CODE: BRLAPNAC

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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: _____					
Number of PACLitaxel doses completed to date: _____					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, platelets day of treatment					
May proceed with doses as written for PACLitaxel NAB portion if labs done within 72 h: ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, Bilirubin less than or equal to 1.5 x ULN, AST or ALT less than or equal to 10 x ULN					
May proceed with doses as written for AC portion if labs done within 72 h: ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 90 x 10⁹/L					
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 _____.					
For cycles with DOXOrubicin and cyclophosphamide:					
dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to AC treatment and select ONE of the following:					
<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment				
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to AC treatment ondansetron 8 mg PO 30 to 60 minutes prior to AC treatment				
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to AC treatment				
<input type="checkbox"/> Other: _____					
CHEMOTHERAPY: (Note – continued over 2 pages)					
<input type="checkbox"/> CYCLE # _____					
PACLitaxel NAB (ABRAXANE) 260 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with 15 micron filter)					
*** SEE PAGE 2 FOR AC CHEMOTHERAPY CYCLES ***					
DOCTOR'S SIGNATURE:					SIGNATURE:

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UC:

DOCTOR'S ORDERS

DATE:

To be given:

Cycle #:

CHEMOTHERAPY: (Continued)

OR

CYCLE # _____

DOXOrubicin 60 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

IV push

cyclophosphamide 600 mg/m² x BSA = _____ mg

Dose Modification: _____ % = _____ mg/m² x BSA = _____ mg

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

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____

Last Cycle. Return in _____ week(s) after last treatment.

Cycles 1 to 4:

CBC & Diff, Platelets, bilirubin, ALT, creatinine prior to each treatment

Cycles 5 to 8:

CBC & Diff, Platelets prior to each treatment

If clinically indicated: **alkaline phosphatase** **GGT** **urea**

If clinically indicated, for cycles 5 to 8: **bilirubin** **ALT** **creatinine**

MUGA **Echocardiogram** **Other tests:**

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: