



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: **GOOVPLDC**

**Class II Drug**

Second line treatment for epithelial ovarian cancer relapsing after primary treatment

<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 1 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L</b> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. If <b>prior</b> infusion reaction: <b>45 minutes prior to DOXOrubicin Liposomal:</b> <input type="checkbox"/> <b>Dexamethasone 20 mg IV</b> in 50 mL NS over 15 minutes <b>30 minutes prior to DOXOrubicin liposomal:</b> <input type="checkbox"/> <b>DiphenhydrAMINE 50 mg IV</b> and <b>Ranitidine 50 mg IV</b> in 50 mL NS over 20 minutes <b>Ondansetron 8 mg PO</b> 30 minutes prior to <b>CARBOplatin.</b> <b>Dexamethasone 8 mg PO</b> 30 minutes prior to <b>CARBOplatin.</b> <input type="checkbox"/> <b>Other:</b> _____				
<b>CHEMOTHERAPY:</b> All lines to be primed with D5W <b>DOXOrubicin liposomal 30 mg/m<sup>2</sup> or 25 mg/m<sup>2</sup> (circle one) x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL D5W. In Cycle 1, infuse over at least 1 hour (maximum rate 1mg/minute). For Cycle greater than or equal to 2 and no previous reaction, infuse over 1 hour.  <b>CARBOplatin AUC 5 or 4 (circle one) x (GFR + 25) = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 250mL D5W over 30 minutes.				
<b>RETURN APPOINTMENT ORDERS</b>				
Return in four weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Treatment. Return in _____ week(s).				
<b>Cycle 1: CBC &amp; Diff, Platelets, creatinine</b> prior to Day 1, and <b>CBC &amp; Diff, Platelets</b> on Days 14, and 21. <b>Subsequent cycles: CBC &amp; Diff, Platelets</b> prior to Day 1; if indicated, also on <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21. Prior to next cycle, if clinically indicated: <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>Alk Phos</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>ALT</b> <input type="checkbox"/> <b>AST</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>Tot Prot</b> <input type="checkbox"/> <b>Albumin</b> <input type="checkbox"/> <b>Creatinine</b> <input type="checkbox"/> <b>CA 15-3</b> <input type="checkbox"/> <b>CA 125</b> <input type="checkbox"/> <b>CA 19-9</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:	