



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 and according to acceptable standards of care.

PROTOCOL CODE: GOOVLDOX

Class II Drug

Progressive/progressing, epithelial ovarian, primary peritoneal or fallopian tube carcinoma, in patient who has not already been treated with topotecan or gemcitabine, which is:

platinum sensitive or platinum contraindicated, platinum refractory, or platinum resistant

*For other indications or for more than 6 cycles, a BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

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 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: (No prophylactic antiemetics usually necessary)					
If prior infusion reaction: 45 minutes prior to DOXOrubicin liposomal: <input type="checkbox"/> Dexamethasone 20 mg IV in 50 mL D5W over 15 minutes 30 minutes prior to DOXOrubicin liposomal: <input type="checkbox"/> Diphenhydramine 50 mg IV and Ranitidine 50 mg IV in 50 mL D5W over 20 minutes <input type="checkbox"/> Other: _____					
CHEMOTHERAPY:					
All lines to be primed with D5W					
doxorubicin liposomal 40 mg/m² or 30 mg/m² (circle one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL D5W over 1 hour* *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. If previous reaction, infuse over at least 1 hour, and no faster than 1 mg/minute					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in four or five weeks (circle one) for Doctor and Cycle ____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC with differential, platelets, prior to each cycle If clinically indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Alk Phos. <input type="checkbox"/> AST <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CEA <input type="checkbox"/> Other tests: _____ <input type="checkbox"/> Consults: _____ <input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE: _____				SIGNATURE: _____	
				UC: _____	