PROTOCOL CODE: GIAAVCT

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:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

On Day 1: May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L**
On Days 8 and 15: May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 75 x 10^9/L**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity:** _____
Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

45 minutes prior to PACLitaxel: dexamethasone 10 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ No pre-medication to PACLitaxel required (see protocol for guidelines)

☐ **dexamethasone** ☐ **8 mg or** ☐ **12 mg** *(select one)* PO prior to CARBOplatin, **if not receiving** IV dexamethasone for PACLitaxel

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to CARBOplatin and **ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to CARBOplatin

If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin
☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

PACLitaxel ☐ **80 mg/m^2** OR ☐ _____ **mg/m^2** x BSA = _____ mg on **Days 1, 8 and 15**
☐ Dose modification: _____ % = _____ mg/m^2 x BSA = _____mg
IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter)

CARBOplatin ☐ **AUC 5** *or* ☐ **AUC 4** *or* ☐ **AUC 3** *(select one)* **x (GFR + 25)** = _____ mg on **Day 1** only
☐ Dose modification: _____ % = _____ mg
IV in 100 to 250 mL NS over 30 minutes

If DOSE MODIFICATION REQUIRED ON DAY 8 OR DAY 15:

☐ **PACLitaxel** ☐ **70 mg/m^2** *or* ☐ **60 mg/m^2** *or* ☐ _____ **mg/m^2** x BSA = _____ mg on **Day 8**
☐ **PACLitaxel** ☐ **70 mg/m^2** *or* ☐ **60 mg/m^2** *or* ☐ _____ **mg/m^2** x BSA = _____ mg on **Day 15**
IV in 100 to 500 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter)

DOCTOR'S SIGNATURE	**SIGNATURE:** **UC:**

DOCTOR'S ORDERS

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle ____. Book chemo room weekly x 3. ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, creatinine, total bilirubin, ALT prior to Day 1 of each cycle **CBC & Diff** prior to treatment on Day 8 and 15 If clinically indicated: ☐ **CEA** ☐ **SCC** ☐ **CA19-9** ☐ **ECG** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**