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, platelets** 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)

ondansetron 8 mg PO 30 minutes prior to CARBOplatin

☐ 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

☐ **Other:**

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

CHEMOTHERAPY:

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:**

DATE:	**To be given:**	**Cycle #:**

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, platelets, creatinine weekly prior to treatment If clinically indicated: ☐ **Bilirubin** ☐ **ALT** ☐ **Magnesium** ☐ **CEA** ☐ **SCC** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**