

PROTOCOL CODE: GUFUPRT

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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: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, creatinine day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9/L$, platelets greater than or equal to $100 \times 10^9/L$, creatinine clearance greater than 75 mL/minute.		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> ECOG/Age <input type="checkbox"/> Other Toxicity: _____ Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to each CISplatin treatment		
AND select ONE of the following:	<input type="checkbox"/> ondansetron 8 mg PO 30 to 60 minutes prior to each CISplatin treatment <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CISplatin treatment on Day 1, then 80 mg PO daily on Days 2 and 3 (<input type="checkbox"/> and 4 if ordered) and ondansetron 8 mg PO 30 to 60 minutes prior to each CISplatin treatment <input type="checkbox"/> netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CISplatin Day 1 only	
If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to each CISplatin treatment <input type="checkbox"/> Other: _____		
CHEMOTHERAPY: CISplatin $25 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ $\text{mg/m}^2 \times \text{BSA} =$ _____ mg IV in 100 to 250 mL NS over 30 minutes x 3 or 4 days (circle one) OR mitomycin C $10 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ $\text{mg/m}^2 \times \text{BSA} =$ _____ mg IV push on Day 1 of every second cycle. Maximum cumulative dose is 20 mg/m^2 fluorouracil $1000 \text{ mg/m}^2/\text{day}$ or _____ $\text{mg/m}^2/24 \text{ hours} \times \text{BSA} =$ _____ mg/day for 4 days (total dose = 4000 mg/m^2 over 96 h) <input type="checkbox"/> Dose Modification: _____ % = _____ $\text{mg/m}^2/\text{day} \times \text{BSA} =$ _____ mg/day for 4 days (total dose = _____ mg over 96h) IV in D5W to a total volume of 480 mL by continuous infusion at 5 mL/h via TWO Baxter LV5 infusors (Total dose should be divided equally- each 240 mL over 48 hours)		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____ <input checked="" type="checkbox"/> Return in 2 days for second fluorouracil infusor <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, creatinine prior to each cycle If clinically indicated: <input type="checkbox"/> total bilirubin , ALT , LDH , alkaline phosphatase <input type="checkbox"/> Other tests: _____ <input type="checkbox"/> Consults: _____ <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE: UC: