PROTOCOL CODE: GOCABR

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

May proceed with doses as written, if within 72 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 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 _____.

dexamethasone ☐ **8 mg or** ☐ **12 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

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 Medications and Protocol Available****

TREATMENT:

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____% = _____mg

IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

CARBOplatin AUC 6 or 5 (circle one) x (GFR + 25) = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250mL NS over 30 minutes.

RETURN APPOINTMENT ORDERS

Return in ☐ **three** weeks, or ☐ **four** weeks for Doctor and Cycle _____.

☐ Last Treatment. Return in _____ week(s).

CBC & Diff, creatinine prior to next cycle.

If indicated: **CBC & Diff** on ☐ Day 14 and/or ☐ Day 21.

Prior to next cycle, if clinically indicated:

☐ **total bilirubin** ☐ **alkaline phosphatase** ☐ **GGT** ☐ **ALT**

☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9** ☐ **CEA** ☐ **SCC**

☐ **Refer to Hereditary Cancer Program (see accompanying referral form)**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: