PROTOCOL CODE: GOCXAJCAT

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

☐ **CBC & Diff**, **Platelets** on _____

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L**

Dose modification made 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 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel:

diphenhydrAMINE 50 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

☐ **Other:**

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

CHEMOTHERAPY:

PACLitaxel ☐ **175 mg/m^2** *or* ☐ **155 mg/m^2** *or* ☐ **135 mg/m^2** (*select one*) x BSA = _____ mg

☐ Dose Modification: 80 % of previous dose = _____ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use Non DEHP tubing with 0.2 micron in-line filter)

CARBOplatin AUC ☐ **6** *or* ☐ **5** (*select one*) **x (GFR + 25)** x = _____ mg

☐ Dose Modification: 80 % of previous dose = _____ mg

IV in 100 to 250 mL NS over 30 minutes

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

DATE:	
RETURN APPOINTMENT ORDERS	
Return in ☐ **three** weeks, or ☐ **four** weeks for Doctor and Cycle _____ ☐ Last Treatment of GOCXAJCAT. Return for GOCXCRT: book to start within 3 days of radiation therapy start.	
CBC & Diff, Platelets, Creatinine prior to next cycle. (*optional)* **CBC & Diff, Platelets** on ☐ Day 14 ☐ Day 21 Prior to next cycle, if clinically indicated: ☐ **Potassium** ☐ **Magnesium** ☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **ALT** ☐ **LDH** ☐ **Tot Prot** ☐ **Albumin** ☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9** ☐ **CEA** ☐ **SCC** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**