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# PROTOCOL CODE: GOCXCATB



## 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) and repeat **CBC & Diff**, **Platelets on** day of treatment

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, BP less than or equal to 150/100, and urine dipstick for protein negative or 1+.

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 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: _____% = _____ mg/$m^2$ x BSA = _____ 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: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

Flush line with **10 mL NS** pre-bevacizumab. Blood pressure measurement pre-bevacizumab dose.

**bevacizumab** ☐ **15 mg/kg** *or* ☐ _____ mg/kg (*select one*) x _____ kg = _____ mg

IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour). Flush line with **25 mL NS** post-bevacizumab.

(Blood pressure measurement post-bevacizumab infusion for first 3 cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

| Drug | Brand (Pharmacist to complete. Please print.) | Pharmacist Initial and Date |
|---|---|---|
| bevacizumab | | |

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

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# PROTOCOL CODE: GOCXCATB



| DATE: | |
|---|---|
| **RETURN APPOINTMENT ORDERS** | |
| Return in ☐ **three** weeks, or ☐ **four** weeks for Doctor and Cycle _____<br><br>☐ Last Treatment. Return in _____ week(s). | |
| *If this is Cycle 1 or if a dose change has been made*: **CBC & Diff, Platelets** on Day 14 (and Day 21 if RTC is in four weeks).<br><br>**CBC & Diff, Platelets, Creatinine, Laboratory urinalysis** *or* **Urine dipstick for protein** prior to next cycle (*within 96 hours OK*).<br><br>**CBC & Diff, Platelets** on ☐ Day 14 ☐ Day 21<br><br>☐ **24 hr urine for total protein** within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein<br><br>☐ **INR** weekly ☐ **INR** prior to next cycle<br><br>Prior to next cycle, if clinically indicated: ☐**Bilirubin** ☐**Alk Phos** ☐**GGT** ☐**ALT**<br><br>☐**LDH** ☐**Tot Prot** ☐**Albumin** ☐**CA 15-3** ☐**CA 125** ☐**CA 19-9** ☐**SCC** ☐**CEA**<br><br>☐ **Other tests:**<br><br>**NB –** *Repeat any positive imaging after every 2 cycles.*<br><br>☐ **Consults:**<br><br>☐ **See general orders sheet for additional requests.** | |
| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |