

**PROTOCOL CODE: GOENDAVCAT**

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<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>
Date of Previous Cycle:		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment May proceed with doses as written if within 96 hours <b>ANC greater than or equal to <math>1.0 \times 10^9/L</math>, Platelets greater than or equal to <math>100 \times 10^9/L</math></b> Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ <b>Proceed with treatment based on blood work from _____</b>		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. <b>45 minutes prior to PACLitaxel:</b> dexamethasone 20 mg IV in 50 mL NS over 15 minutes <b>30 minutes prior to PACLitaxel:</b> 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)		
AND select ONE of the following:	<input type="checkbox"/> ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin	
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 CARBOplatin <input type="checkbox"/> Other: _____		
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>		
<b>TREATMENT:</b> <b>PACLitaxel</b> <input type="checkbox"/> 175 mg/m <sup>2</sup> or <input type="checkbox"/> _____ mg/m <sup>2</sup> (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL NS (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter) <b>CARBOplatin AUC</b> <input type="checkbox"/> 6 or <input type="checkbox"/> 5 (select one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250mL NS over 30 minutes.		
<b>RETURN APPOINTMENT ORDERS</b>		
Return in <input type="checkbox"/> <b>three</b> weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Treatment. Return in _____ week(s).		
<b>CBC &amp; Diff, creatinine, total bilirubin, ALT, alkaline phosphatase</b> prior to next cycle. Prior to next cycle, if clinically indicated: <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CEA <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b> <b>UC:</b>