PROTOCOL CODE: GOOVCAG

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht__________cm</th>
<th>Wt__________kg</th>
<th>BSA__________m²</th>
</tr>
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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

May proceed with doses as written if within 24 hours ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/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 ____________________________.

ondansetron 8 mg PO prior to CARBOplatin

dexamethasone 8 mg PO prior to CARBOplatin

**Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY:

DAY 1

gemcitabine ☐ 800 mg/m² OR ☐ _________ mg/m² (select one) x BSA = _________ mg

☐ Dose Modification: _________% = _________ mg/m² x BSA = _________ mg

IV in 250 mL NS over 30 minutes. (Maximum Dose = 2000 mg)

CARBOplatin AUC ☐ 5 OR ☐ 6 OR ☐ 4 (select one) X (GFR+25) = _________ mg

☐ Dose Modification: _________% = _________ mg

IV in 250 mL NS over 30 minutes, after gemcitabine.

DAY 8

gemcitabine ☐ 800 mg/m² OR ☐ _________ mg/m² (select one) x BSA = _________ mg

☐ Dose Modification: _________% = _________ mg/m² x BSA = _________ mg

IV in 250 mL NS over 30 minutes. (Maximum Dose = 2000 mg)

RETURN APPOINTMENT ORDERS

☐ Return in three weeks for Doctor and Cycle #_________. Book chemo Day 1 and 8

☐ Last Cycle. Return in _______ week(s).

CBC & Diff, Platelets, Creatinine, prior to Day 1 each cycle

CBC & Diff, Platelets, prior to Day 8 each cycle

☐ Day 14: CBC & Diff, platelets

Other tests: ☐ Nuclear renogram for GFR

If Clinically Indicated: ☐ CA -125 ☐ CA 15-3 ☐ CA 19-9 prior to each cycle

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: ____________________________

SIGNATURE: ____________________________

UC: ____________________________