PROTOCOL CODE: GOOVCATM

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

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 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 ☐ _____ **mg/m^2** (select one) x BSA =_____ mg

☐ Dose Modification: _____% = _____mg/m^2 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)

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

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL 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, Platelets, Creatinine prior to next cycle.

If this is Cycle 1: **CBC & Diff, Platelets** on Day 14.

If this is Cycle 1 and indicated: ☐CT Scan chest/abdo/pelvis between Cycles 2 & 3

☐ Referral to Gyne Onc Surgeons after CT Scan

If this is Cycle 1 and RTC is in 4 weeks: **CBC & Diff, Platelets** on Day 21.

In subsequent cycles, if indicated: **CBC & Diff, Platelets** on ☐ Day 14 and/or ☐ Day 21.

Prior to next cycle, if clinically indicated:

☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **ALT** ☐ **LDH**
☐ **Tot Prot** ☐ **Albumin**
☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9**

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

☐ **Consults:** ☐ **Other tests:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: