PROTOCOL CODE: GOOVDDCAT

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

On Day 1: May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L**

On Days 8 and 15: May proceed with doses as written if within 24 hours **ANC greater than or equal to 0.5 x 10^9/L, Platelets greater than or equal to 50 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 _____.

ondansetron 8 mg PO 30 minutes prior to **CARBOplatin.**

45 minutes prior to PACLitaxel:

dexamethasone 10 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel:

diphenhydrAMINE 25 mg IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

☐ No pre-medication to PACLitaxel required (see protocol for guidelines)

If not receiving IV dexamethasone for PACLitaxel, give: **dexamethasone** ☐ **8** *or* ☐ **12 mg** (*select one*) PO prior to CARBOplatin.

☐ **Other:**

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

CHEMOTHERAPY:

DAY 1

PACLitaxel ☐ **70 mg/m²** *or* ☐ 60 mg/m² *or* ☐ 80 mg/m² *or* _____ mg/m² (*select one*) x BSA = _____ mg

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

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour use non-DEHP tubing with 0.2 micron in-line filter).

CARBOplatin AUC ☐ **6** *or* ☐ 5 *or* ☐ 4 (*select one*) **x (GFR + 25)** = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

DAY 8 and 15

PACLitaxel ☐ **70 mg/m²** *or* ☐ 60 mg/m² *or* ☐ 80 mg/m² *or* _____ mg/m² (*select one*) x BSA = _____ mg

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

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter).

***if* DOSE MODIFICATION REQUIRED ON DAY 8 OR DAY 15:**

PACLitaxel ☐ **60 mg/m²** *or* ☐ 50 mg/m² *or* ☐ _____mg/m² (*select one*) x BSA = _____ mg

IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter) once weekly x ☐ ONE *or* ☐ TWO weeks (*select one*)

DOCTOR'S SIGNATURE & DATE MODIFICATION MADE:_____

DOCTOR'S SIGNATURE:

RN:

UC:

PROTOCOL CODE: GOOVDDCAT

DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle____. Book chemo room weekly x 3.

☐ Delay next cycle until _____weeks after surgery.

Book Doctor and tentative Cycle _____. Obtain O.R. and Pathology Reports in time for RTC.

Date of Surgery (if known): _____

☐ Last Treatment. Return in _____ week(s).

CBC & Diff, Platelets prior to each treatment on Days 1, 8, 15.

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

☐ Referral to Gyne Onc Surgeons after CT Scan

Prior to next cycle, if clinically indicated:

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

☐ For RTC post-surgery: **CBC & Diff, Platelets, Creatinine, CA 125**.

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

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

RN:

UC: