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

Proced 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
  - dexamethasone 10 mg IV in 50 mL NS over 15 minutes
  - dexamethasone 10 mg IV in 50 mL NS over 15 minutes
  - diphendhydrAMINE 25 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes
  - No pre-medication to PACLitaxel required (see protocol for guidelines)

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

**Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY:

DAY 1
- PACLitaxel 70 mg/m^2 or 60 mg/m^2 or 80 mg/m^2 or ________ mg/m^2 (circle one) x BSA = ________ mg
- Dose Modification: ________% = ________ mg/m^2 x BSA = ________ mg
- IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter)
- CARBOplatin AUC 6 or 5 or 4 (circle one) x (GFR + 25) = ________ mg
- Dose Modification: ________% = ________ mg
- IV in 250 mL NS over 30 minutes

DAY 8 and 15

- PACLitaxel 70 mg/m^2 or 60 mg/m^2 or 80 mg/m^2 or ________ mg/m^2 (circle one) x BSA = ________ mg
- Dose Modification: ________% = ________ mg/m^2 x BSA = ________ mg
- IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter)

if DOSE MODIFICATION REQUIRED ON DAY 8 OR DAY 15:
- PACLitaxel 60 mg/m^2 or 50 mg/m^2 or ________ mg/m^2 (circle one) x BSA = ________ mg
- IV in 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.22 micron or smaller in-line filter)
one weekly x ONE or TWO weeks (circle 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
- [ ] AST
- [ ] 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:**

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