**Protocol Code: GOOVLDOX**

**Doctor's Orders**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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Reminder: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**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 $1 \times 10^9$/L, Platelets greater than or equal to $100 \times 10^9$/L.

Dose modification for:
- [ ] Hematology
- [ ] Other Toxicity __________________________

Proceed with treatment based on blood work from ______

**Premedications:** (No prophylactic antiemetics usually necessary)

If prior infusion reaction:

- 45 minutes prior to DOXOrubicin pegylated liposomal (CAELYX):
  - [ ] Dexamethasone 20 mg IV in 50 mL D5W over 15 minutes
- 30 minutes prior to DOXOrubicin pegylated liposomal (CAELYX):
  - [ ] DiphenhydrAMINE 50 mg IV and Ranitidine 50 mg IV in 50 mL D5W over 20 minutes

- [ ] Other:

**Chemotherapy:**

All lines to be primed with D5W.

DOXOrubicin pegylated liposomal (CAELYX) [ ] 40 mg/m² or [ ] 30 mg/m² (select one) x BSA = ________ mg

Dose Modification: ________mg/m² x BSA = ________mg

IV in 250 to 500 mL D5W over 1 hour*

*In Cycle 1, infuse over at least 1 h (maximum 1 mg/min). For subsequent doses and no prior reaction, infuse over 1 h.

**Return Appointment Orders**

- [ ] Return in [ ] four or [ ] five weeks (select one) for Doctor and Cycle ___
- [ ] Last Cycle. Return in ______ week(s).

CBC with differential, platelets, prior to each cycle

If clinically indicated:

- [ ] Tot. Prot
- [ ] Albumin
- [ ] Bilirubin
- [ ] GGT
- [ ] Alk Phos.
- [ ] AST
- [ ] LDH
- [ ] ALT
- [ ] BUN
- [ ] Creatinine
- [ ] CA 125
- [ ] CA 19-9
- [ ] CA 15-3
- [ ] CEA

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

**Doctor's Signature:**

**Signature:**

UC: