**PROTOCOL CODE: GOOVLDOX**

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

**To be given:**

**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:** (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 (circle 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 1mg/min). For subsequent doses and no prior reaction, infuse over 1 h.

**RETURN APPOINTMENT ORDERS**

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

**CBC with differential, platelets, prior to each cycle**

- [ ] 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:**