PROTOCOL CODE: GOOVPLDC

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 _____.

If ***prior*** infusion reaction: **45 minutes prior to DOXOrubicin pegylated liposomal:**
☐ **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes
30 minutes prior to DOXOrubicin pegylated liposomal:
☐ **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.**
dexamethasone 8 mg PO 30 minutes prior to **CARBOplatin**.
☐ **Other:**

****Have Hypersensitivity Reaction Medications and Protocol Available****

CHEMOTHERAPY:
All lines to be primed with D5W (CARBOplatin is compatible with both NS and D5W)

DOXOrubicin pegylated liposomal ☐ **30 mg/m^2** *or* ☐ **25 mg/m^2** *(select one)* x BSA =_____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 mL D5W over 1 h*
*In Cycle 1, infuse over at least 1 h (maximum 1mg/min). For subsequent doses and no prior reaction, infuse over 1 h.
CARBOplatin AUC ☐ **5** *or* ☐ **4** *(select one)* **x (GFR + 25)** = _____ mg
☐ Dose Modification: _____% = _____ mg
IV in 100 to 250 mL NS over 30 minutes.

RETURN APPOINTMENT ORDERS

Return in four weeks for Doctor and Cycle _____
☐ Last Treatment. Return in _____ week(s).

Cycle 1: CBC & Diff, Platelets, Creatinine prior to Day 1, and **CBC & Diff, Platelets** on Days 14, and 21.
Subsequent cycles: CBC & Diff, Platelets, Creatinine prior to Day 1;
if indicated, also 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** ☐ **CEA**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: