



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care

### PROTOCOL CODE: LULAPE2RT

|  |                     |                 |                     |                          |
|--|---------------------|-----------------|---------------------|--------------------------|
| <b>DOCTOR'S ORDERS</b>   |                     | Ht _____ cm     | Wt _____ kg         | BSA _____ m <sup>2</sup> |
| <b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>  |                     |                 |                     |                          |
| <b>DATE:</b>   | <b>To be given:</b> | <b>Cycle #:</b> | <b>of 2 (max 2)</b> |                          |
| Date of Previous Cycle: _____  |                     |                 |                     |                          |
| <input type="checkbox"/> Delay treatment _____ week(s)<br><input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment<br>May proceed with doses as written if within 96 hours <b>ANC greater than or equal to 1.5 x 10<sup>9</sup>/L, Platelets greater than or equal to 100 x 10<sup>9</sup>/L, Creatinine Clearance greater than or equal to 60 mL/minute (if using cisplatin)</b><br>Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____<br><b>Proceed with treatment based on blood work from</b> _____  |                     |                 |                     |                          |
| <b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.<br><b>ondansetron 8 mg PO</b> prior to treatment on Days 1 to 5 and Day 8 (CISplatin)<br><b>dexamethasone 8 mg or 12 mg (circle one) PO</b> prior to treatment on Days 1 to 5 and Day 8 (CISplatin)<br><input type="checkbox"/> <b>hydrocortisone 100 mg IV</b> prior to etoposide<br><input type="checkbox"/> <b>diphenhydrAMINE 50 mg IV</b> prior to etoposide<br><input type="checkbox"/> <b>Other:</b> _____   |                     |                 |                     |                          |
| <b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>  |                     |                 |                     |                          |
| <b>HYDRATION:</b><br>1000 mL NS over 1 hour prior to CISplatin Day 1 and Day 8   |                     |                 |                     |                          |
| <b>CHEMOTHERAPY:</b><br><b>CISplatin 50 mg/m<sup>2</sup>/day</b> x BSA = _____ mg<br><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg<br>IV in 500 mL NS with potassium chloride 20 mEq, magnesium sulphate 1 g and mannitol 30 g over 1 hour on <b>Day 1 and Day 8</b><br><b>OR</b><br><b>CARBOplatin AUC 5 x (GFR + 25) = _____ mg IV</b> in 100 to 250 mL NS over 30 minutes on <b>Day 1 only</b><br><br><b>etoposide 50 mg/m<sup>2</sup>/day</b> x BSA = _____ mg<br><input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg<br>IV in 250 to 500 mL (non-DEHP bag) NS over 45 minutes on Days 1 to 5 (use non-DEHP tubing with 0.2 micron in-line filter) |                     |                 |                     |                          |
| <b>STANDING ORDER FOR ETOPOSIDE TOXICITY:</b><br><b>hydrocortisone 100 mg IV prn / diphenhydrAMINE 50 mg IV prn</b>  |                     |                 |                     |                          |
| <b>RETURN APPOINTMENT ORDERS</b>   |                     |                 |                     |                          |
| <input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____. Book chemo for Days 1 to 5 and Day 8<br><input type="checkbox"/> Last Cycle. Return in _____ week(s).   |                     |                 |                     |                          |
| <b>CBC &amp; Diff, Platelets, Creatinine, Bilirubin</b> prior to each cycle. <b>Creatinine</b> on Day 8.<br>If clinically indicated: <input type="checkbox"/> <b>Bilirubin</b><br><input type="checkbox"/> <b>Other tests:</b><br><input type="checkbox"/> <b>Consults:</b><br><input type="checkbox"/> <b>See general orders sheet for additional requests</b>  |                     |                 |                     |                          |
| <b>DOCTOR'S SIGNATURE:</b>   |                     |                 | <b>SIGNATURE:</b>   |                          |
|  |                     |                 | <b>UC:</b>          |                          |