

PROTOCOL CODE: LUSCPERT

Page 1 of 1

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: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment		
May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9/L$, Platelets greater than or equal to $100 \times 10^9/L$, Creatinine Clearance greater than or equal to 60 mL/minute (if using cisplatin), Creatinine Clearance greater than or equal to 30 mL/minute for etoposide Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO 30 to 60 minutes prior to treatment on Days 1 to 3 dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to treatment on Days 1 to 3 <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to treatment on Day 1; then 80 mg PO daily on Day 2 and 3 If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to treatment <input type="checkbox"/> hydrocortisone 100 mg IV prior to etoposide <input type="checkbox"/> diphenhydrAMINE 50 mg IV prior to etoposide <input type="checkbox"/> Other: _____		
Have Hypersensitivity Reaction Tray and Protocol Available		
TREATMENT: CISplatin 25 mg/m²/day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 100 to 250 mL NS over 30 minutes x 3 days OR CARBOplatin AUC 5 x (GFR + 25) = _____ mg IV in 100 to 250 mL NS over 30 minutes Day 1 only etoposide 100 mg/m²/day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 1000 mL (non-DEHP bag) NS over 45 minutes to 1 hour 30 minutes x 3 days (use non-DEHP tubing with 0.2 micron in-line filter)		
RETURN APPOINTMENT ORDERS		
<input type="checkbox"/> Return in <input type="checkbox"/> three or <input type="checkbox"/> four (select one) weeks for Doctor and Cycle _____. Book chemo x 3 days. <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
CBC & Diff, creatinine prior to each cycle If clinically indicated: <input type="checkbox"/> total bilirubin <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE: UC: