PROTOCOL CODE: CNCARV

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** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, Creatinine Clearance greater than or equal to 60 mL/min and if ordered, ALT less than or equal to 5 x ULN, and bilirubin less than or equal to 25 micromol/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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment on Day 1

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1 **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment on Day 1
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment on Day 1

☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to Day 1

☐ **hydrocortisone 100 mg** IV prior to etoposide

☐ **diphenhydrAMINE 50 mg** IV prior to etoposide

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

TREATMENT:

CARBOplatin AUC 5 x (GFR + 25) = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes

etoposide 100 mg/m^2 x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 250 to 1000 mL (use non-DEHP bag) NS over 45 min to 1 hour 30 min (use non-DEHP tubing with 0.2 micron in-line filter)

RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____

☐ Last Cycle. Return in _____ week(s).

CBC & Diff, creatinine prior to each cycle

CBC & Diff on ☐ **Day 14** ☐ **Day 21**

If clinically indicated: ☐ **Total bilirubin** ☐ **ALT**

☐ **sodium, potassium** ☐ **calcium** ☐ **magnesium**

☐ **CT head or** ☐ **MRI head** *(select one)* **every** ☐ **2nd cycle or** ☐ **3rd cycle** *(select one)*

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: