PROTOCOL CODE: GUMITO

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 started:**

Dose modification for: ☐ **Toxicity** _____

Proceed with treatment based on bloodwork from _____**(Only necessary for initiation of treatment)**

CHEMOTHERAPY: (or TREATMENT – if non chemo)

1. **mitotane** Starting dose is _____mg (standard dose 500 mg) PO four times daily x ___weeks,
then ____mg PO in the morning, ____mg PO at noon, ____mg PO in the evening, ____mg PO at night x ___weeks,
then ____mg PO in the morning, ____mg PO at noon, ____mg PO in the evening, ____mg PO at night x ___weeks
(escalate dose once every 1 to 2 weeks to maximum tolerated dose, usually about 3 grams per day)

Mitte: _____ **weeks supply**

2. Cortisone acetate 25 mg PO every morning and 12.5 mg PO every evening **(OMIT if serum cortisol elevated)**

Mitte _____weeks supply

3. **Fludrocortisone acetate** 0.1 mg PO every morning PO **(OMIT if serum cortisol elevated).**

Mitte _____weeks supply

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor

☐ Treatment complete when present supply of mitotane used up. Return in _____ week(s) from date of these orders.

TESTS:

Baseline: CBC & Diff, sodium, potassium, ALT, Alk Phos, bilirubin, Serum Cortisol

☐ **CBC & Diff, Platelets, sodium, potassium, creatinine, ALT, Alk Phos, bilirubin** 1 week prior to next appointment with oncologist

Additional tests to be done 1 week prior to next appointment with oncologist

☐ **DHEAS**
☐ **24-hr Urine for Cortisol**
☐ **Serum Cortisol**
☐ **Total Prot** ☐ **Albumin** ☐ **GGT** ☐ **Alk Phos**
☐ **LDH**
☐ **CT scan of _____ in _____weeks**
☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: