

**PROTOCOL CODE: LUAVNP**

(Page 1 of 1)

<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>		
DATE:	To be given:	Cycle #:
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment May proceed with doses as written if within 24 hours <b>ANC greater than or equal to 1.0 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> Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____ <b>Proceed with treatment based on blood work from</b> _____		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.		
dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) 30 to 60 minutes prior to treatment		
AND select ONE of the following:	<input type="checkbox"/> ondansetron 8 mg PO 30 to 60 minutes prior to treatment <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to treatment, and ondansetron 8 mg PO 30 to 60 minutes prior to treatment <input type="checkbox"/> netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment	
If additional antiemetic required: <input type="checkbox"/> <b>OLANzapine</b> <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 prn <input type="checkbox"/> Other: _____		
<b>CHEMOTHERAPY:</b>		
CISplatin 30 mg/m <sup>2</sup> /day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 100 to 250 mL NS over 30 minutes on <b>Day 1 and Day 8</b>		
vinorelbine 30 mg/m <sup>2</sup> /day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 50 mL NS over 6 minutes on <b>Day 1 and Day 8</b> Flush vein with 75 to 125 mL NS following infusion of vinorelbine.		
<b>DOSE MODIFICATION – CARBOPLATIN OPTION:</b>		
CARBOplatin AUC 5 x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 30 minutes on <b>Day 1 only</b>		
vinorelbine 25 mg/m <sup>2</sup> /day x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 50 mL NS over 6 minutes on <b>Day 1 and Day 8</b> Flush vein with 75 to 125 mL NS following infusion of vinorelbine.		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____. Book chemo Day 1 and 8. <input type="checkbox"/> Last Cycle. Return in _____ week(s).		
<b>CBC &amp; Diff, Platelets, Creatinine</b> prior to each treatment If clinically indicated: <input type="checkbox"/> <b>Bilirubin</b> <input type="checkbox"/> <b>Other tests:</b> <input type="checkbox"/> <b>Consults:</b> <input type="checkbox"/> <b>See general orders sheet for additional requests.</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>