

PROTOCOL CODE: GOENDAJCAT

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 1.0 x 10⁹/L, platelets greater than or equal to 100 x 10⁹/L 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 _____. 45 minutes prior to PACLitaxel: dexamethasone 20 mg IV in 50 mL NS over 15 minutes 30 minutes prior to PACLitaxel: diphenhydrAMINE 50 mg IV in NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible)		
AND select ONE of the following:	<input type="checkbox"/> ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin	
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 CARBOplatin <input type="checkbox"/> Other: _____		
Have Hypersensitivity Reaction Tray and Protocol Available		
TREATMENT: PACLitaxel <input type="checkbox"/> 175 mg/m ² or <input type="checkbox"/> _____ mg/m ² (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL NS (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter) CARBOplatin AUC <input type="checkbox"/> 6 or <input type="checkbox"/> 5 (select one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250mL NS over 30 minutes.		
RETURN APPOINTMENT ORDERS		
Return in <input type="checkbox"/> three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Treatment. Return in _____ week(s).		
CBC & Diff, creatinine, total bilirubin, ALT prior to next cycle. If clinically indicated: <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CEA <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> LDH <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> magnesium <input type="checkbox"/> calcium <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE: UC: