Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: GOOVCAD

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**

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 PO BID for 3 days, starting one day prior to each treatment; patient must receive minimum of three doses pre-treatment

ondansetron 8 mg PO 30 minutes prior to CARBOplatin

☐ **aprepitant 125 mg** PO 30 to 60 minutes prior to CARBOplatin

If additional antiemetic required:

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

Optional: **Frozen gloves** starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.

☐ **Other:**

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

TREATMENT:

DOCEtaxel ☐ **75 mg/m^2** ***or*** ☐ **60 mg/m^2** (*select one*) x BSA =_____ mg

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

IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour. (Use non-DEHP tubing)

CARBOplatin AUC ☐ **5** ***or*** ☐ **4** (*select one*) **x (GFR + 25)** =_____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250mL NS over 30 minutes.

RETURN APPOINTMENT ORDERS

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

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

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

CBC & Diff, creatinine prior to next cycle.

If this is Cycle 1: **CBC & Diff** on Day 7 & 14.

If this is Cycle 1 and indicated: ☐CT Scan chest/abdo/pelvis between Cycles 2 & 3

☐ Referral to Gyne Onc Surgeons after CT Scan

In subsequent cycles, if indicated: ☐ **CBC & Diff** on Day 7 & 14.

Prior to next cycle, if clinically indicated:

☐ **total bilirubin** ☐ **alkaline phosphatase** ☐ **ALT** ☐ **sodium** ☐ **potassium**

☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9** ☐ **CEA** ☐ **SCC**

☐ **Consults:**

☐ **Other tests:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: