



Provincial Health Services Authority

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](http://www.bccancer.bc.ca/terms-of-use) and according to acceptable standards of care.

**PROTOCOL CODE: GOOVCATM**

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**DOCTOR'S ORDERS**

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

**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 1.0 x 10<sup>9</sup>/L, platelets greater than or equal to 100 x 10<sup>9</sup>/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 \_\_\_\_\_.

**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"/>	<b>ondansetron 8 mg PO</b> 30 to 60 minutes prior to CARBOplatin
	<input type="checkbox"/>	<b>aprepitant 125 mg PO</b> 30 to 60 minutes prior to CARBOplatin, and <b>ondansetron 8 mg PO</b> 30 to 60 minutes prior to CARBOplatin
	<input type="checkbox"/>	<b>netupitant-palonosetron 300 mg-0.5 mg PO</b> 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
- Other:** \_\_\_\_\_

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

**TREATMENT:**

**PACLitaxel**  **175 mg/m<sup>2</sup>** OR  \_\_\_\_\_ **mg/m<sup>2</sup>** (select one) x BSA = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg/m<sup>2</sup> 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**  **6** or  **5 (select one)** x (GFR + 25) = \_\_\_\_\_ mg

Dose Modification: \_\_\_\_\_ % = \_\_\_\_\_ mg

IV in 100 to 250 mL NS over 30 minutes.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**



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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
Return in <input type="checkbox"/> <b>three</b> weeks, or <input type="checkbox"/> <b>four</b> weeks for Doctor and Cycle _____	
<input type="checkbox"/> Last Treatment. Return in _____ week(s).	
<b>CBC &amp; Diff, creatinine, total bilirubin, ALT</b> prior to next cycle.	
<i>If this is Cycle 1 and indicated:</i> <input type="checkbox"/> CT Scan chest/abdo/pelvis between Cycles 2 & 3 <input type="checkbox"/> Referral to Gyne Onc Surgeons after CT Scan	
<i>If indicated:</i> <b>CBC &amp; Diff</b> on <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21.	
Prior to next cycle, if clinically indicated:	
<input type="checkbox"/> <b>alkaline phosphatase</b> <input type="checkbox"/> <b>LDH</b> <input type="checkbox"/> <b>GGT</b>	
<input type="checkbox"/> <b>sodium</b> <input type="checkbox"/> <b>potassium</b> <input type="checkbox"/> <b>magnesium</b> <input type="checkbox"/> <b>calcium</b>	
<input type="checkbox"/> <b>CA 15-3</b> <input type="checkbox"/> <b>CA 125</b> <input type="checkbox"/> <b>CA 19-9</b> <input type="checkbox"/> <b>CEA</b> <input type="checkbox"/> <b>SCC</b>	
<input type="checkbox"/> <b>Refer to Hereditary Cancer Program (see accompanying referral form)</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>