

**PROTOCOL CODE: GOOVCATR**

<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>				
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle #:</b>		
Date of Previous Cycle: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff</b> day of treatment				
May proceed with doses as written if within 96 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</b>				
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____				
Proceed with treatment based on blood work from _____				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.				
<b>45 minutes prior to PACLitaxel:</b>				
dexamethasone 20 mg IV in 50 mL NS over 15 minutes				
<b>30 minutes prior to PACLitaxel:</b>				
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 <b>ONE</b> of the following:	<input type="checkbox"/>   <input type="checkbox"/>  <input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin  aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin  netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin		
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 CARBOplatin <input type="checkbox"/> <b>Other:</b> _____				
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>				
<b>TREATMENT:</b>				
<b>PACLitaxel 175 mg/m<sup>2</sup> or _____ mg/m<sup>2</sup> x BSA = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter)				
<b>CARBOplatin AUC 6 or 5 (circle one) x (GFR + 25) = _____ mg</b> <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 30 minutes.				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				<b>UC:</b>

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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<p>Return in <input type="checkbox"/> <b>three</b> weeks, or <input type="checkbox"/> <b>four</b> weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Last Treatment. Return in _____ week(s).</p>	
<p><b>CBC &amp; Diff, creatinine, total bilirubin, ALT</b> prior to next cycle.  <i>If this is Cycle 1: CBC &amp; Diff on Day 14.</i>  <i>If this is Cycle 1 and RTC is in 4 weeks: CBC &amp; Diff on Day 21.</i></p> <p><i>In subsequent cycles, if indicated: CBC &amp; Diff on <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21.</i></p> <p>Prior to next cycle, if clinically indicated:</p> <p><input type="checkbox"/> alkaline phosphatase   <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></p> <p><input type="checkbox"/> Other tests:  <input type="checkbox"/> Consults:  <input type="checkbox"/> See general orders sheet for additional requests.</p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>
	<b>UC:</b>