

PROTOCOL CODE: GOOVCATX

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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/m² OR <input type="checkbox"/> _____ mg/m² (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² 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)				
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 250 mL NS over 30 minutes.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC:

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DATE:	
RETURN APPOINTMENT ORDERS	
Return in <input type="checkbox"/> three weeks, or <input type="checkbox"/> four weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Treatment. Return in _____ week(s).	
CBC & Diff, creatinine, total bilirubin, ALT 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: CBC & Diff on</i> <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21. Prior to next cycle, if clinically indicated: <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"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CEA <input type="checkbox"/> SCC <input type="checkbox"/> Refer to Hereditary Cancer Program (see accompanying referral form) <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: