

PROTOCOL CODE: GOOVDDCAT

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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 On Day 1: May proceed with doses as written if within 48 hours ANC greater than or equal to 1.0 x 10⁹/L, platelets greater than or equal to 100 x 10⁹/L On Days 8 and 15: May proceed with doses as written if within 48 hours ANC greater than or equal to 0.5 x 10⁹/L, platelets greater than or equal to 50 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 10 mg IV in 50 mL NS over 15 minutes					
30 minutes prior to PACLitaxel: diphenhydrAMINE 25 mg IV in NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible)					
<input type="checkbox"/> No pre-medication to PACLitaxel required (see protocol for guidelines)					
If not receiving IV dexamethasone for PACLitaxel, give: dexamethasone <input type="checkbox"/> 8 or <input type="checkbox"/> 12 mg (select one) PO prior to CARBOplatin.					
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:					
DAY 1					
PACLitaxel <input type="checkbox"/> 70 mg/m ² or <input type="checkbox"/> 60 mg/m ² or <input type="checkbox"/> 80 mg/m ² or _____ mg/m ² (select one) x BSA = _____ mg					
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg					
IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour use non-DEHP tubing with 0.2 micron in-line filter).					
CARBOplatin AUC <input type="checkbox"/> 6 or <input type="checkbox"/> 5 or <input type="checkbox"/> 4 (select one) x (GFR + 25) = _____ mg					
<input type="checkbox"/> Dose Modification: _____ % = _____ mg					
IV in 100 to 250 mL NS over 30 minutes.					
DAY 8 and 15					
PACLitaxel <input type="checkbox"/> 70 mg/m ² or <input type="checkbox"/> 60 mg/m ² or <input type="checkbox"/> 80 mg/m ² or _____ mg/m ² (select one) x BSA = _____ mg					
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg					
IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter).					
DOCTOR'S SIGNATURE:					RN:
					UC:

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DOCTOR'S ORDERS

DATE:

if DOSE MODIFICATION REQUIRED ON DAY 8 OR DAY 15:

PACLitaxel 60 mg/m² or 50 mg/m² or _____ mg/m² (select one) x BSA = _____ mg
 IV in 100 to 250 mL (non-DEHP bag) NS over 1 hour (use non-DEHP tubing with 0.2 micron in-line filter)
 once weekly x ONE or TWO weeks (select one)

DOCTOR'S SIGNATURE & DATE MODIFICATION MADE: _____

RETURN APPOINTMENT ORDERS

- Return in **three** weeks for Doctor and Cycle _____. Book chemo room weekly x 3.
- Delay next cycle until _____ weeks after surgery.
 Book Doctor and tentative Cycle _____. Obtain O.R. and Pathology Reports in time for RTC.
 Date of Surgery (if known): _____
- Last Treatment. Return in _____ week(s).

CBC & Diff, creatinine, total bilirubin, ALT prior to Day 1 of each cycle.
CBC & Diff prior to Days 8 and 15 of each cycle.

If this is Cycle 1 and indicated: CT Scan chest/abdo/pelvis between Cycles 2 & 3
 Referral to Gyne Onc Surgeons after CT Scan

Prior to next cycle, if clinically indicated:

- alkaline phosphatase** **GGT** **LDH** **magnesium** **sodium** **potassium**
- calcium** **CA 15-3** **CA 125** **CA 19-9** **CEA** **SCC**

- For RTC post-surgery: **CBC & Diff, creatinine, CA 125**
- Refer to Hereditary Cancer Program (see accompanying referral form)
- Other tests:
- Consults:
- See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

RN:

UC: