



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 and according to acceptable standards of care

PROTOCOL CODE: **GOOVFPLDC**

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

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 10⁹/L**, **platelets greater than or equal to 100 x 10⁹/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 _____.

If **prior** infusion reaction: **45 minutes prior to DOXOrubicin pegylated liposomal:**

dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to DOXOrubicin pegylated liposomal:

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)

dexamethasone 8 mg PO 30 to 60 minutes 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:

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

Other: _____

****Have Hypersensitivity Reaction Medications and Protocol Available****

TREATMENT:

All lines to be primed with D5W (CARBOplatin is compatible with both NS and D5W)

DOXOrubicin pegylated liposomal 30 mg/m² or 25 mg/m² (select one) x BSA = _____ mg

Dose Modification: _____ mg/m² x BSA = _____ mg

IV in 250 mL D5W over 1 h*

*In Cycle 1, infuse over at least 1 h (maximum 1mg/min). For subsequent doses and no prior reaction, infuse over 1 h.

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

Dose Modification: _____ % = _____ mg

IV in 100 to 250mL NS over 30 minutes.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

PROTOCOL CODE: GOOVFPLDC

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| | |
|---|---------------------------------|
| DATE: | |
| RETURN APPOINTMENT ORDERS | |
| Return in four weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Treatment. Return in _____ week(s). | |
| <p>CBC & Diff, creatinine prior to each cycle.</p> <p>If indicated:</p> <p>CBC & Diff on <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21</p> <p><input type="checkbox"/> total bilirubin <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> magnesium <input type="checkbox"/> calcium</p> <p><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</p> <p><input type="checkbox"/> Refer to Hereditary Cancer Program (see accompanying referral form)</p> <p><input type="checkbox"/> Other tests:</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p> | |
| DOCTOR'S SIGNATURE: | SIGNATURE: UC: |