



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

**PROTOCOL CODE: GOOVLDOX**

<b>DOCTOR'S ORDERS</b>			Ht _____ cm	Wt _____ kg	BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form					
<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> _____ <b>Proceed with treatment based on blood work from</b> _____					
<b>PREMEDICATIONS:</b> (No prophylactic antiemetics usually necessary)					
If <b>prior</b> infusion reaction: <b>45 minutes prior to DOXOrubicin pegylated liposomal:</b> <input type="checkbox"/> <b>dexamethasone 20 mg IV</b> in 50 mL D5W over 15 minutes <b>30 minutes prior to DOXOrubicin pegylated liposomal:</b> <input type="checkbox"/> <b>diphenhydrAMINE 50 mg IV</b> in NS 50 mL over 15 minutes and <b>famotidine 20 mg IV</b> in NS 100 mL over 15 minutes (Y-site compatible) <input type="checkbox"/> <b>Other:</b>					
<b>TREATMENT:</b>					
All lines to be primed with D5W					
<b>DOXOrubicin pegylated liposomal 40 mg/m<sup>2</sup> or 30 mg/m<sup>2</sup></b> (select one) x BSA = _____ mg					
<input type="checkbox"/> Dose Modification: _____ mg/m <sup>2</sup> x BSA = _____ mg					
IV in 250 to 500 mL D5W over 1 hour*					
*In Cycle 1, infuse over at least 1 h (maximum 1mg/min). For subsequent doses and no prior reaction, infuse over 1 h.					
<b>RETURN APPOINTMENT ORDERS</b>					
<input type="checkbox"/> Return in <b>four</b> or <b>five</b> weeks ( <i>select one</i> ) for Doctor and Cycle ____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).					
<b>CBC &amp; Diff</b> prior to each cycle  If clinically indicated: <input type="checkbox"/> <b>echocardiogram</b> or <input type="checkbox"/> <b>MUGA</b> <input type="checkbox"/> <b>total bilirubin</b> <input type="checkbox"/> <b>creatinine</b> <input type="checkbox"/> <b>sodium</b> <input type="checkbox"/> <b>potassium</b> <input type="checkbox"/> <b>CA 125</b> <input type="checkbox"/> <b>CA 19-9</b> <input type="checkbox"/> <b>CA 15-3</b> <input type="checkbox"/> <b>CEA</b> <input type="checkbox"/> <b>SCC</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>	