PROTOCOL CODE: GOENDAJCAT

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:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff**, **Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/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 _____.

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:	☐	**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:

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

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

CHEMOTHERAPY:

PACLItaxel ☐ **175 mg/m^2** *or* ☐ _____ **mg/m^2** (*select one*) x BSA =_____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____mg

IV in 250 to 500 mL NS (non-DEHP bag) over 3 hours (use non-DEHP tubing with 0.2 micron in-line filter)

CARBOplatin AUC ☐ **6** *or* ☐ **5** (*select one*) **x (GFR + 25)** = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250mL NS over 30 minutes.

RETURN APPOINTMENT ORDERS

Return in ☐ **three** weeks for Doctor and Cycle _____

☐ Last Treatment. Return in _____ week(s).

CBC and differential, creatinine, total bilirubin, ALT, alkaline phosphatase, albumin prior to next cycle.

Prior to next cycle, if clinically indicated:

☐ **GGT** ☐ **Total Protein**

☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9**

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: