

PROTOCOL CODE: GOOVFPLDC

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, Platelets 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 _____.					
If prior infusion reaction: 45 minutes prior to DOXOrubicin pegylated liposomal:					
<input type="checkbox"/> dexamethasone 20 mg IV in 50 mL NS over 15 minutes					
30 minutes prior to DOXOrubicin pegylated liposomal:					
<input type="checkbox"/> 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:					
<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 Medications and Protocol Available					
CHEMOTHERAPY:					
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					
<input type="checkbox"/> Dose Modification: _____ mg/m ² 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					
<input type="checkbox"/> Dose Modification: _____ % = _____ mg					
IV in 100 to 250mL NS over 30 minutes.					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

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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>Cycle 1: CBC & Diff, Platelets, Creatinine prior to Day 1, and CBC & Diff, Platelets on Days 14, and 21.</p> <p><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</p> <p>Subsequent cycles: CBC & Diff, Platelets, Creatinine prior to Day 1; if indicated, also on <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21.</p> <p>Prior to next cycle, if clinically indicated: <input type="checkbox"/> Bilirubin <input type="checkbox"/> Alk Phos <input type="checkbox"/> GGT <input type="checkbox"/> ALT <input type="checkbox"/> LDH <input type="checkbox"/> Tot Prot <input type="checkbox"/> Albumin <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9</p> <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: