PROTOCOL CODE: GOOVCATR

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**, **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/m² *or* _____ mg/m² x BSA =_____ mg

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

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

CARBOplatin AUC 6 or 5 (circle one) x (GFR + 25) = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:	
RETURN APPOINTMENT ORDERS	
Return in ☐ **three** weeks, or ☐ **four** weeks for Doctor and Cycle _____ ☐ Last Treatment. Return in _____ week(s).	
CBC & Diff, Platelets, Creatinine prior to next cycle. *If this is Cycle 1*: **CBC & Diff, Platelets** on Day 14. *If this is Cycle 1 and RTC is in 4 weeks*: **CBC & Diff, Platelets** on Day 21. *In subsequent cycles, if indicated*: **CBC & Diff, Platelets** on ☐ Day 14 and/or ☐ Day 21. Prior to next cycle, if clinically indicated: ☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **ALT** ☐ **LDH** ☐ **Tot Prot** ☐ **Albumin** ☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9** ☐ **Other tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**