PROTOCOL CODE: GOCXCATB

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) and repeat **CBC & Diff**, **Platelets on** 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, BP less than or equal to 150/100,** and **urine dipstick for protein negative or 1+.**

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* ☐ **155 mg/m^2** *or* ☐ **135 mg/m^2** (*select one*) x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 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** (*select one*) **x (GFR + 25)** x = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

Flush line with **10 mL NS** pre-bevacizumab. Blood pressure measurement pre-bevacizumab dose.

bevacizumab ☐ **15 mg/kg** *or* ☐ _____ mg/kg (*select one*) x _____ kg = _____ mg

IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour). Flush line with **25 mL NS** post-bevacizumab.

(Blood pressure measurement post-bevacizumab infusion for first 3 cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
bevacizumab		

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).	
If this is Cycle 1 or if a dose change has been made: **CBC & Diff, Platelets** on Day 14 (and Day 21 if RTC is in four weeks). **CBC & Diff, Platelets, Creatinine, Laboratory urinalysis** *or* **Urine dipstick for protein** prior to next cycle (*within 96 hours OK*). **CBC & Diff, Platelets** on ☐ Day 14 ☐ Day 21 ☐ **24 hr urine for total protein** within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein ☐ **INR** weekly ☐ **INR** prior to next cycle Prior to next cycle, if clinically indicated: ☐**Bilirubin** ☐**Alk Phos** ☐**GGT** ☐**ALT** ☐**LDH** ☐**Tot Prot** ☐**Albumin** ☐**CA 15-3** ☐**CA 125** ☐**CA 19-9** ☐**SCC** ☐**CEA** ☐ **Other tests:** **NB –** *Repeat any positive imaging after every 2 cycles.* ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**