

**PROTOCOL CODE: GOENDCAT**

<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, Platelets</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"/> Hematology <input type="checkbox"/> Other Toxicity _____ <b>Proceed with treatment based on blood work from _____</b>				
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____.				
<b>45 minutes prior to PACLitaxel:</b> dexamethasone 20 mg IV in 50 mL NS over 15 minutes				
<b>30 minutes prior to PACLitaxel:</b> 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:	<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:				
<b>**Have Hypersensitivity Reaction Tray and Protocol Available**</b>				
<b>CHEMOTHERAPY:</b>				
PACLitaxel <input type="checkbox"/> 175 mg/m <sup>2</sup> or <input type="checkbox"/> _____ mg/m <sup>2</sup> (select one) x BSA = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg/m <sup>2</sup> 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 <input type="checkbox"/> 6 or <input type="checkbox"/> 5 (select one) x (GFR + 25) = _____ mg				
<input type="checkbox"/> Dose Modification: _____ % = _____ mg				
IV in 100 to 250mL NS over 30 minutes.				
<b>RETURN APPOINTMENT ORDERS</b>				
Return in <input type="checkbox"/> <b>three</b> weeks, or <input type="checkbox"/> <b>four</b> weeks for Doctor and Cycle _____				
<input type="checkbox"/> Last Treatment. Return in _____ week(s).				
<b>CBC &amp; Diff, Platelets, Creatinine</b> prior to next cycle.				
If this is Cycle 1: <b>CBC &amp; Diff, Platelets</b> on Days 14 (and 21 if four-week return).				
In subsequent cycles, if indicated: <b>CBC &amp; Diff, Platelets</b> on <input type="checkbox"/> Day 14 and/or <input type="checkbox"/> Day 21.				
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 <input type="checkbox"/> CEA				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
<b>DOCTOR'S SIGNATURE:</b>				<b>SIGNATURE:</b>
				<b>UC:</b>