PROTOCOL CODE: GOCXCAD

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 1.5 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 _____.

dexamethasone 8 mg PO BID for 3 days, starting one day prior to each treatment; patient must receive minimum of three doses pre-treatment

ondansetron 8 mg PO 30 minutes prior to CARBOplatin

☐ **aprepitant 125 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

Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing.

☐ **Other:**

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

CHEMOTHERAPY:

DOCEtaxel ☐ **75 mg/m^2** *or* ☐ **60 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 1 hour. (Use non-DEHP tubing)

CARBOplatin AUC ☐ **5** *or* ☐ **4** *(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 Cycle. Return in _____ week(s).

CBC & Diff, Platelets on ☐ Day 7 ☐ Day 14.

CBC & Diff, Platelets, Creatinine 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**

☐ **Other tests:**

☐ **Consults:**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: