Nausea Prevention & Treatment

BEP: Aprepitant (IV)-Palonosetron-Dexamethasone-Prochlorperazine

- The following is a calendar to instruct you when to take your medicine.
- These medicines were prescribed to both prevent you from feeling nauseous ("sick to your stomach") and treat nausea if it occurs after your chemotherapy.
- The days and dates are listed down the left column. The approximate time of day that you should take the medicine is listed across the top.
- It is important to take your medicine as instructed even if you are feeling well. It is easier to prevent nausea and vomiting than to treat it once it occurs.
- If these medicines are not helping you or you think they are causing a side effect(s) please call 732-235-2465 and ask for the Nurse Help Line. Ask for your doctor if after 5 p.m. or on a weekend.

Aprepitant (IV)= Cinvanti®, Palonosetron = Aloxi®, Dexamethasone = Decadron®, Prochlorperazine = Compazine®

Date	Medication	7 A.M.	12 Noon	6 P.M.	11 P.M.
Days 1-5 **Date: ___/___/___** ***Please Circle Day 1*** **Sn, M, T, W, Th, F, S**	**Aprepitant (IV) 130 mg IV injection**	**Given by a nurse before chemotherapy on days 1 & 4**			
	Palonosetron 0.25 mg IV injection	**Given by a nurse before chemotherapy on days 1 & 4**			
	Dexamethasone 4 mg tablet	**Given by a nurse before chemotherapy on days 1, 2, 3, 4 & 5**			
	Prochlorperazine 10 mg tablet			**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***
Day 6 **Date: ___/___/___** ***Please Circle*** **Sn, M, T, W, Th, F, S**	**Dexamethasone 4 mg tablet**	**Two (2) Tablets** ***with food or milk***			
	Prochlorperazine 10 mg tablet	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***
Day 7 **Date: ___/___/___** ***Please Circle*** **Sn, M, T, W, Th, F, S**	**Dexamethasone 4 mg tablet**	**Two (2) Tablets** ***with food or milk***			
	Prochlorperazine 10 mg tablet	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***
Day 8 **Date: ___/___/___** ***Please Circle*** **Sn, M, T, W, Th, F, S**	**Dexamethasone 4 mg tablet**	**Two (2) Tablets** ***with food or milk***			
	Prochlorperazine 10 mg tablet	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***
Day 9 and afterwards **Date: ___/___/___** ***Please Circle*** **Sn, M, T, W, Th, F, S**	**Prochlorperazine 10 mg tablet**	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***	**One (1) Tablet** ***Only If Needed***

If you are in need of immediate assistance, please call 732-235-2465 and select the option that best meets your needs.

