



Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: UHNLACETRT

A BCCA "Compassionate Access Program" (CAP) request form must be completed and approved prior to treatment.

DOCTOR'S ORDERS Height _____ cm Weight _____ kg BSA = $\sqrt{\frac{\text{Height (cm) x Weight (kg)}}{3600}}$ = _____ m ²	
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form	
DATE: _____	To be given: _____
Day(s): _____	
Date of Previous Cycle: _____	
Baseline: CBC + diff, platelet, magnesium, calcium, albumin, lytes, creatinine Dose modification for: <input type="checkbox"/> Severe acneiform rash Rate modification for: <input type="checkbox"/> Allergic/Hypersensitivity reactions Proceed with treatment based on bloodwork from _____	
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____ Diphenhydramine 50 mg PO 30 to 60 minutes prior to each Cetuximab dose <input type="checkbox"/> Other: _____	
** Have Hypersensitivity Reaction Tray and protocol available**	
TREATMENT: VITAL SIGNS: Temperature, Pulse, Respiration, Blood Pressure pre-Cetuximab infusion, halfway through infusion and one hour post infusion. * Patients are to be observed visually for the first 15 minutes of Cetuximab infusion. <i>(*Observe for 1 hour following end of 1st and 2nd infusion. May discontinue observation period if no infusion reaction for 2 consecutive doses.)</i> Flush Cetuximab line post infusion with Normal Saline (0.9% Sodium Chloride Injection) <input type="checkbox"/> DAY minus 7 from radiation start date: Cetuximab (first dose) 400 mg/m² X BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV over 2 hours (use 0.22 micron in-line filter) Infusion rate not to exceed 10 mg/minute. Observe for 1 hour following infusion. Concurrent with Radiation Therapy (choose days below): <input type="checkbox"/> DAY 1, 8, 15, 22, 29, 36 <input type="checkbox"/> DAY 1, 8, 15, 22, 29 if radiation is given over 5 weeks, or <input type="checkbox"/> DAY 1, 8, 15, 22, 29, 36, 43 if radiation is given over 7 weeks Cetuximab (subsequent dose) 250 mg/m² X BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV over 1 hour (use 0.22 micron in-line filter) <input type="checkbox"/> Decrease infusion rate by 50% for previous allergic/hypersensitivity reaction. Start time of observation: _____ End time of observation: _____	
RN to assess for severe acneiform rash prior to EACH Cetuximab infusion Notify Doctor of any signs and symptoms of toxicity prior to administering Cetuximab	
RETURN APPOINTMENT ORDERS	
Book Chemo weekly x 6, 7 or 8 weeks (<i>circle one</i>) total Return to Clinic in _____ week(s) for Doctor with CBC & diff, platelets, magnesium, calcium, albumin, lytes, creatinine Day 22: CBC & diff, platelets, magnesium, calcium, albumin, lytes, creatinine <input type="checkbox"/> Last Cycle. Return in _____ week(s).	
<input type="checkbox"/> Tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE: _____	SIGNATURE: _____ UC: _____