



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: GICART

Class II Drug:

Squamous cell or cloacogenic carcinoma of the anal canal.

For other indications a BCCA "Compassionate Access Program" request form must be completed and approved prior to treatment

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: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff, Platelets, Creatinine day of treatment May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/min.				
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____				
Proceed with treatment based on blood work from _____				
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.				
<input type="checkbox"/> Ondansetron 8 mg PO prior to chemotherapy <input type="checkbox"/> Dexamethasone 8 mg PO prior to chemotherapy <input type="checkbox"/> Metoclopramide 10-20 mg PO prn prior to chemotherapy <input type="checkbox"/> Prochlorperazine 10 mg PO prn prior to chemotherapy <input type="checkbox"/> Other: _____				
CHEMOTHERAPY: Chemotherapy begins on Day 1 of each radiotherapy course				
Mitomycin 12 mg/m² x BSA x (_____ %) = _____ mg IV push on Day 1, Week 1. (Maximum dose = 20 mg)				
Capecitabine 825 mg/m² x BSA x (_____ %) = _____ mg PO bid with food. The second dose should be taken 10-12 hours after the first dose. (Total daily dose = 1650 mg/m ²) To be dispensed in appropriate weekly intervals, Monday to Friday with Saturday, Sunday and statutory holidays off x 6 weeks.				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Radiation Therapy to start Week 1 x 5½ weeks <input type="checkbox"/> Return in _____ weeks for Doctor assessment during RT <input type="checkbox"/> Return in _____ weeks for Doctor and _____ week for PO capecitabine <input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff, Platelets, Creatinine, weekly prior to treatment CBC & Diff, Platelets, Creatinine, weekly for 2 weeks after chemoradiation <input type="checkbox"/> Other tests: _____ <input type="checkbox"/> Weekly Nursing Assessment <input type="checkbox"/> Consults: _____ <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	