BC Cancer Agency
CARE & RESEARCH

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: UGICOXB

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

DOCTOR'S ORDERS

Ht____________**cm** **Wt**____________**kg** **BSA**____________**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle(s) #:**

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 1.2 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than 50 mL/minute, BP less than or equal to 160/100**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** ____

Proceed with treatment based on blood work from ____________________________

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ______________________________.

Ondansetron 8 mg PO prior to treatment

Dexamethasone 8 mg or **12 mg** *(circle one)* PO prior to treatment

☐ **Other:**

☐ **Calcium Gluconate 1000 mg** and **Magnesium Sulfate 1000 mg** given together in 250 mL D5W IV over 20 minutes **pre** and **post** Oxaliplatin

CHEMOTHERAPY: ☐ **Repeat in three weeks**

Oxaliplatin 130 mg/m² x BSA = _________ mg

☐ Dose Modification: ____________mg/m² x BSA = __________mg

IV in 250 to 500 mL D5W over 2 hours

Bevacizumab 7.5 mg/kg x __________ kg = __________ mg

IV in 100 mL NS over 15 minutes via infusion pump. Flush line with 10 mL NS pre and post dose.

(Blood pressure measurement pre and post dose for first 3 cycles and prior to Bevacizumab for subsequent cycles.)

Capecitabine 1000 mg/m² or ______ x BSA x (________%) = ________ mg PO bid with food x 14 days

(Round to nearest 150 mg)

DOCTOR'S SIGNATURE:

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DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _______ ☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles ☐ Last Cycle. Return in _________ week(s)	
CBC & Diff, Platelets, Creatinine, Bili, AST, Alk Phos, Albumin, Electrolytes and Blood Pressure Measurement prior to each cycle **Dipstick Urine or laboratory urinalysis for protein** at the beginning of each **even** numbered cycle. (If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then a **24 hr urine for total protein** must be done within 3 days prior to next cycle.) ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **Other tests:** ☐ **Weekly Nursing Assessment** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**