



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: UGIAVCETIR

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 #:** _____

Date of Previous Cycle: _____

Delay treatment _____ week(s)
 CBC & Diff day of treatment
 May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/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 _____.
Ondansetron 8 mg PO prior to treatment
Dexamethasone 8 mg or 12 mg (circle one) PO 30 minutes prior to Cetuximab
Diphenhydramine 50 mg PO 30 minutes prior to Cetuximab
 Prophylactic Atropine 0.3 mg SC
 Other: _____

Magnesium Sulfate 2G in 250 mL NS over 60 minutes for hypomagnesemia
 Magnesium Sulfate 4G in 1000 mL NS over 3 hours for hypomagnesemia

CHEMOTHERAPY:
Cycle 1:
Cetuximab (first dose) 500 mg/m² x BSA = _____ mg
 Dose Modification: _____ mg/m² x BSA = _____ mg
 IV over **2 hours** using a 0.22 micron in-line filter. Observe for 1 hour post infusion. Obtain vital signs pre-infusion, at 1 hour and post-infusion*.
Irinotecan 180 mg/m² x BSA = _____ mg
 Dose Modification: _____ mg/m² x BSA = _____ mg
 IV in 500 mL D5W over 1 hour 30 min

Cycle 2 and higher: **Repeat in two weeks** **Repeat in two and in four weeks**
Cetuximab (subsequent dose) 500 mg/m² x BSA = _____ mg
 Dose Modification: _____ mg/m² x BSA = _____ mg
 IV over **1 hour (use 0.22 micron in-line filter)**. Obtain vital signs pre-infusion and 1 hour post-infusion*.
***Observe for 1 hour following end of 1st and 2nd infusion. May discontinue observation period if no infusion reaction for 2 consecutive doses.**
Irinotecan 180 mg/m² x BSA = _____ mg
 Dose Modification: _____ mg/m² x BSA = _____ mg
 IV in 500 mL D5W over 1 hour 30 min

DOCTOR'S SIGNATURE: _____

SIGNATURE: _____
 UC: _____



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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 #:		
Counsel patient to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO q 2 h until diarrhea free x 12 hours (may take 4 mg PO q 4 h during the night).				
Atropine 0.3 – 0.6 mg SC prn repeat up to 1.2 mg for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.				
RETURN APPOINTMENT ORDERS				
<input type="checkbox"/> Return in two weeks for Doctor and Cycle _____				
<input type="checkbox"/> Return in four weeks for Doctor and Cycles ____ & _____. Book chemo x 2 cycles				
<input type="checkbox"/> Last Cycle. Return in _____ week(s)				
CBC & Diff, Electrolytes, Magnesium and Calcium prior to each cycle				
<input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle				
<input type="checkbox"/> Other tests:				
<input type="checkbox"/> Book for PICC assessment / insertion per Centre process				
<input type="checkbox"/> Book for IVAD insertion per Centre process				
<input type="checkbox"/> Consults:				
<input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:			SIGNATURE:	
			UC:	