**PROTOCOL CODE: GIAVPANI**

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht__________cm</th>
<th>Wt________kg</th>
<th>BSA _________ m²</th>
</tr>
</thead>
</table>

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)  

Dose modification for:  

- Dermatologic toxicity  
- Other Toxicity

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

- magnesium sulfate 2 g in 50 mL NS over 30 minutes for hypomagnesemia  
- magnesium sulfate 5 g in 100 mL NS over 3 hours for hypomagnesemia

**Have Hypersensitivity Reaction Tray and Protocol Available**

**TREATMENT:**  

Repeat in two weeks  

PANitumumab 6 mg/kg x ______ kg = ________ mg  

- Dose Modification: 4.5 mg/kg OR 3 mg/kg (circle one) x ______ kg = ________mg  
  IV in 100 mL NS over 1 hour. Use 0.22 micron in-line filter.  
  If tolerated, administer over 30 minutes in subsequent cycles. For PANitumumab doses greater than 1000 mg, use 150 mL NS and infuse over 1 hour 30 min each cycle.

**RETURN APPOINTMENT ORDERS**

- Return in two weeks for Doctor and Cycle ________.
- Return in four weeks for Doctor and Cycle ________.

Sodium, potassium, magnesium and calcium prior to each cycle

- CEA
- Other tests:
- Weekly Nursing Assessment for rash:
- Consults:
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**