

**PROTOCOL CODE: GIAVPANI**

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<b>DOCTOR'S ORDERS</b> Ht _____ cm Wt _____ kg BSA _____ m <sup>2</sup>		
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:		
<input type="checkbox"/> Delay treatment _____ week(s) Blood work to be done within 96 hours prior to treatment. Dose modification for: <input type="checkbox"/> <b>Dermatologic toxicity</b> <input type="checkbox"/> <b>Other Toxicity</b> <b>Proceed with treatment based on blood work from _____</b>		
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____		
<input type="checkbox"/> magnesium sulfate 2 g in 50 mL NS over 30 minutes for hypomagnesemia <input type="checkbox"/> magnesium sulfate 5 g in 100 mL NS over 3 hours for hypomagnesemia		
<b>** Have Hypersensitivity Reaction Tray and Protocol Available**</b>		
<b>TREATMENT:</b> <input type="checkbox"/> Repeat in two weeks <b>PANitumumab 6 mg/kg</b> x _____ kg = _____ mg <input type="checkbox"/> Dose Modification: 4.5 mg/kg OR 3 mg/kg (circle one) x _____ kg = _____ mg IV in 100 mL NS over 1 hour. If tolerated, administer over 30 minutes in subsequent cycles. Use 0.2 micron in-line filter.		
<b>RETURN APPOINTMENT ORDERS</b>		
<input type="checkbox"/> Return in <b>two</b> weeks for Doctor and Cycle _____. <input type="checkbox"/> Return in <b>four</b> weeks for Doctor and Cycle _____.		
<b>Sodium, potassium, magnesium and calcium</b> prior to each cycle <input type="checkbox"/> CEA <input type="checkbox"/> Other tests: <input type="checkbox"/> Weekly Nursing Assessment for rash: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b> <b>UC:</b>