PROTOCOL CODE: GIAVRALIR

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:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 10^9/L and creatinine clearance greater than or equal to 65 mL/min**

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** *(select one)* PO prior to treatment
☐ Prophylactic **atropine 0.3 mg** subcutaneously 30 minutes prior to irinotecan
☐ **Other:**

TREATMENT: ☐ **Repeat in three weeks** ☐ **Repeat in four weeks**

raltitrexed ☐ **3 mg/m^2** or ☐ _____ mg/m^2 (select one) x BSA = _____ mg
IV in 100 mL NS over 15 minutes

irinotecan ☐ **180 mg/m^2** or ☐ _____ mg/m^2 (select one) x BSA = _____mg
IV in 500 mL D5W over 1 hour 30 minutes

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 mg subcutaneously prn. May repeat every 30 min to a **maximum dose of 1.2 mg** for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in **four** weeks for Doctor and Cycle _____
☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book treatment x 2 cycles
☐ Return in **eight** weeks for Doctor and Cycle _____ & _____. Book treatment x 2 cycles
☐ Last cycle. Return in _____ week(s)

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle

If clinically indicated:
☐ **CEA** ☐ **CA 19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **Other tests:**
☐ **Weekly nursing assessment for (specify concern):**_____
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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