PROTOCOL CODE: GIAVRALOX

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 (omit if below dexamethasone IV premedication ordered)

☐ For prior oxaliplatin hypersensitivity reactions (Grade 1 or 2):
45 minutes prior to oxaliplatin: **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes
30 minutes prior to oxaliplatin: **diphenhydrAMINE 50 mg** IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)
NO ice chips
☐ **Other:**

****Have Hypersensitivity Reaction Tray & Protocol Available****

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

Prior to starting oxaliplatin, flush lines with D5W (oxaliplatin is NOT compatible with NS)

oxaliplatin ☐ **130 mg/m^2** or ☐ _____ mg/m^2 (select one) x BSA = _____mg IV in 250 to 500 mL D5W over 120 minutes

For moderate vascular pain during oxaliplatin peripheral administration:
250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn
OR ☐ 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn

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**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Book for PICC assessment / insertion per Centre process**
☐ **Book for IVAD insertion per Centre process**
☐ **Weekly nursing assessment for (specify concern):** _____
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

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