

PROTOCOL CODE: GICAPIRI

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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(s) #:
Date of Previous Cycle: _____		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to $1.5 \times 10^9/L$, platelets greater than or equal to $75 \times 10^9/L$, creatinine clearance greater than 50 mL/min Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> 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 <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO prior to treatment <input type="checkbox"/> Prophylactic atropine 0.3 mg subcutaneously 30 minutes prior to irinotecan <input type="checkbox"/> Other: _____		
TREATMENT: <input type="checkbox"/> Repeat in three weeks irinotecan 200 mg/m^2 x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 500 mL D5W over 1 hour 30 minutes capecitabine 800 mg/m^2 or _____ x BSA X (_____ %) = _____ mg PO BID x 14 days (refer to <u>Capecitabine Suggested Tablet Combination Table</u> for dose rounding)		
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		
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Return in six weeks for Doctor and Cycle _____ & _____. Book treatment x 2 cycles <input type="checkbox"/> Last Cycle. Return in _____ week(s)		
CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA19-9 <input type="checkbox"/> ECG <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Weekly nursing assessment <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: