PROTOCOL CODE: GIFFOXB

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:

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

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.2 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, BP less than or equal to 160/100.** For those patients on warfarin, **hold bevacizumab if INR greater than 3**

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: (Note – continued over 2 pages)

☐ **Repeat in two weeks** ☐ **Repeat in two and in four weeks**

oxaliplatin line to be primed with D5W; bevacizumab line to be primed with NS

oxaliplatin 85 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours*

leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted)

☐ **leucovorin 400 mg/m^2** x BSA = _____ mg
IV in 250 mL D5W over 2 hours*

* oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site.

OR

☐ **leucovorin 20 mg/m^2** x BSA = _____ mg
IV push

*** CONTINUED ON PAGE 2 ***

DOCTOR'S SIGNATURE: **SIGNATURE:**
UC:

DATE:

TREATMENT: (Continued)

flourouracil IV push (optional)

☐ **fluorouracil 400 mg/m²** x BSA = _____ mg

☐ Dose Modification: _____mg/m² x BSA = _____mg
IV push

bevacizumab 5 mg/kg x _____ kg = _____ mg
IV in 100 mL NS over 15 minutes. Flush line with NS pre and post dose.
(Blood pressure measurement pre and post dose for first 3 cycles and prior to bevacizumab for subsequent cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
bevacizumab		

fluorouracil infusion (required)

fluorouracil 2400 mg/m² x BSA = _____ mg**
☐ Dose Modification : _____mg/m² x BSA = _____mg**
IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR

** For 3000 to 5500 mg dose, **select INFUSOR per dose range below (doses outside** dose banding range are **prepared as ordered**):

Dose Banding Range	Dose Band INFUSOR (mg)	Pharmacist Initial and Date
Less than 3000 mg	Pharmacy to mix specific dose	
3000 to 3400 mg	3200 mg	
3401 to 3800 mg	3600 mg	
3801 to 4200 mg	4000 mg	
4201 to 4600 mg	4400 mg	
4601 to 5000 mg	4800 mg	
5001 to 5500 mg	5250 mg	
Greater than 5500 mg	Pharmacy to mix specific dose	

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **two** weeks for Doctor and Cycle _____ ☐ Return in **four** weeks for Doctor and Cycles _____ & _____. Book chemo x 2 cycles. ☐ Return in **six** weeks for Doctor and Cycles ____, ____ & ____. Book chemo x 3 cycles. ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle **Dipstick Urine or laboratory urinalysis for protein** at the beginning of each **even** numbered cycle. (If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then: ☐ **24 hr urine for total protein** must be done within 3 days prior to next 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:** **UC:**