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, Platelets 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 3.0

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 (circle one) PO prior to treatment
- NO ice chips
- ☐ Other:

CHEMOTHERAPY: (Note – continued over 2 pages)

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

- 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 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

- fluorouracil 400 mg/m^2 x BSA = ________ mg
- Dose Modification: __________mg/m^2 x BSA = ________mg
- IV push

- bevacizumab 5 mg/kg x ________ kg = ________ mg
- IV in 100 mL NS over 10 minutes via infusion pump. Flush line with 25 mL NS pre and post dose.

(Blood pressure measurement pre and post dose for first 3 cycles and prior to bevacizumab for subsequent cycles)

*** SEE PAGE 2 FOR FLUOROURACIL INFUSIONAL CHEMOTHERAPY ***

DOCTOR'S SIGNATURE: SIGNATURE:

UC:
Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: GIFFOXB

DATE:

CHEMOTHERAPY: (Continued)
fluorouracil 2400 mg/m\(^2\) x BSA = _______ mg**

☐ Dose Modification: ___________mg/m\(^2\) 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):

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

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, Platelets, Creatinine, Bili, ALT, Alk Phos, Albumin, Sodium, Potassium, Mg, Ca and Blood Pressure Measurement 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 a 24 hr urine for total protein must be done within 3 days prior to next cycle.)

☐ INR weekly ☐ INR prior to each cycle

☐ ECG ☐ CEA ☐ CA 19-9

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: ___________