

PROTOCOL CODE: GIFFOXPAN

(Page 1 of 3)

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 72 hours ANC greater than or equal to $1.2 \times 10^9/L$, platelets greater than or equal to $75 \times 10^9/L$					
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 (omit if below dexamethasone IV premedication ordered) <input type="checkbox"/> 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 <input type="checkbox"/> Other: _____					
<input type="checkbox"/> magnesium sulfate 2 g in 50 mL NS over 30 min for hypomagnesemia <input type="checkbox"/> magnesium sulfate 5 g in 100 mL NS over 3 hours for hypomagnesemia					
Have Hypersensitivity Reaction Tray and Protocol Available					
TREATMENT: (Note – continued over 2 pages) <input type="checkbox"/> Repeat in two weeks <input type="checkbox"/> Repeat in two and in four weeks PANitumumab 6 mg/kg x _____ kg = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/kg x _____ kg = _____ mg IV in 100 mL NS over 1 hour. If tolerated, administer over 30 minutes in subsequent cycles. Use 0.2 micron in-line filter. Flush lines with NS pre and post PANitumumab infusion. Prior to starting oxaliplatin, flush lines with D5W oxaliplatin 85 mg/m² x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL D5W over 2 hours*					
*** CONTINUED ON PAGE 2 ***					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

PROTOCOL CODE: GIFFOXPAN

(Page 2 of 3)

DATE:

TREATMENT: (Continued)

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

☐ **leucovorin 400 mg/m² 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/m² x BSA = _____ mg**
IV push

flourouracil

IV push (optional)

☐ **fluorouracil 400 mg/m² x BSA = _____ mg**
☐ Dose Modification: _____ mg/m² x BSA = _____ mg
IV push

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	

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UC:

PROTOCOL CODE: GIFFOXPAN

(Page 3 of 3)

DATE:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in two weeks for Doctor and Cycle ____ <input type="checkbox"/> Return in four weeks for Doctor and Cycles ____ & _____. Book treatment x 2 cycles. <input type="checkbox"/> Return in six weeks for Doctor and Cycles ____, ____ & _____. Book treatment x 3 cycles. <input type="checkbox"/> Last Cycle. Return in _____ week(s).	
CBC & Diff, creatinine, total bilirubin, ALT, magnesium prior to each cycle If clinically indicated: <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> ECG <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> calcium <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"/> Book for PICC assessment / insertion per Centre process <input type="checkbox"/> Book for IVAD insertion per Centre process <input type="checkbox"/> Weekly Nursing Assessment for (specify concern): _____ <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: