

PROTOCOL CODE: GIGAJCOX

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 $1.2 \times 10^9/L$, platelets greater than or equal to $75 \times 10^9/L$, creatinine clearance greater than 50 mL/minute 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: _____		
** Have Hypersensitivity Reaction Tray & Protocol Available**		
TREATMENT: All lines to be primed with D5W <input type="checkbox"/> Repeat in three weeks oxaliplatin $130 \text{ mg/m}^2 \times \text{BSA} = \text{_____ mg}$ <input type="checkbox"/> Dose Modification: _____ $\text{mg/m}^2 \times \text{BSA} = \text{_____ mg}$ IV in 250 to 500 mL D5W over 2 hours or moderate vascular pain during oxaliplatin peripheral administration 250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn OR <input type="checkbox"/> 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn capecitabine <input type="checkbox"/> 1000 mg/m^2 or <input type="checkbox"/> _____ mg/m^2 (select one) $\times \text{BSA} \times (\text{_____} \%) = \text{_____ mg}$ PO BID x 14 days (refer to <u>Capecitabine Suggested Tablet Combination Table</u> for dose rounding)		
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 for (specify concern): _____ <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.		
DOCTOR'S SIGNATURE:		SIGNATURE:
		UC: