



Provincial Health Services Authority

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](http://www.bccancer.bc.ca) and according to acceptable standards of care

**PROTOCOL CODE: GIGAJFFOX**

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## DOCTOR'S ORDERS

Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg BSA \_\_\_\_\_ m<sup>2</sup>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:** \_\_\_\_\_ **To be given:** \_\_\_\_\_ **Cycle #:** \_\_\_\_\_ **and** \_\_\_\_\_

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  $1.2 \times 10^9/L$** , platelets **greater than or equal to  $75 \times 10^9/L$**

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

All lines to be primed with D5W

**oxaliplatin  $85 \text{ mg/m}^2 \times \text{BSA} =$  \_\_\_\_\_ mg**

☐ Dose Modification: \_\_\_\_\_  $\text{mg/m}^2 \times \text{BSA} =$  \_\_\_\_\_ mg

IV in 250 to 500 mL D5W over 2 hours\*

**leucovorin  $400 \text{ mg/m}^2 \times \text{BSA} =$  \_\_\_\_\_ 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  $20 \text{ mg/m}^2 \times \text{BSA} =$  \_\_\_\_\_ mg**  
IV push

**\*\*\* CONTINUED ON PAGE 2 \*\*\***

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**



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**DATE:**

**TREATMENT: (Continued)**

fluorouracil 400 mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

☐ Dose Modification: \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg

IV push **THEN**

fluorouracil ☐ 2400 mg/m<sup>2</sup> or ☐ \_\_\_\_\_ mg/m<sup>2</sup> (select one) x BSA = \_\_\_\_\_ mg\*\*

☐ Dose Modification: \_\_\_\_\_ mg/m<sup>2</sup> 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	

### RETURN APPOINTMENT ORDERS

- ☐ Return in **two** weeks for Doctor and Cycle \_\_\_\_\_
- ☐ Return in **four** weeks for Doctor and Cycles \_\_\_\_\_ & \_\_\_\_\_. Book **treatment** x 2 cycles.
- ☐ Return in **six** weeks for Doctor and Cycles \_\_\_\_\_ & \_\_\_\_\_ & \_\_\_\_\_. Book **treatment** x 3 cycles.
- ☐ Last Cycle. Return in \_\_\_\_\_ week(s).

**CBC & Diff, creatinine, total bilirubin, ALT** prior to each cycle

If clinically indicated:

- ☐ **CEA** ☐ **CA19-9** ☐ **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.**

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