**PROTOCOL CODE: GIGAVCC**

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

- **To be given:**
- **Cycle #:**

**Date of Previous Cycle:**

- **Delay treatment** ______ week(s)

- **CBC & diff, platelets, creatinine, sodium and potassium** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to** 1.5 x 10⁹/L, **Platelets greater than or equal to** 100 x 10⁹/L, and **Creatinine Clearance greater than or equal to** 60 mL/minute.

**Dose modification for:**

- **Hematology**
- **Other Toxicity**

Proceed with treatment based on blood work from ________________.

**PREMEDICATIONS:**

- Patient to take own supply. RN/Pharmacist to confirm ________________.

  - **dexamethasone**: □ 8 mg or □ 12 mg (select one) PO 30 to 60 minutes prior to chemotherapy on Day 1
  - and select ONE of the following:
    - **ondansetron 8 mg** PO 30 to 60 minutes prior to chemotherapy on Day 1
    - **aprepitant 125 mg** PO 30 to 60 minutes prior to chemotherapy on Day 1, then **80 mg** PO daily on Day 2 and 3
    - **ondansetron 8 mg** PO 30 to 60 minutes prior to chemotherapy on Day 1
    - **netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to chemotherapy on Day 1
  - **prochlorperazine 10 mg** PO prn prior to chemotherapy
  - **metoclopramide 10 mg** PO prn prior to chemotherapy
  - **Other**

**PRE-HYDRATION:**

- 1000 mL NS over 1 hour pre-CISplatin

**CHEMOTHERAPY:**

- **CISplatin 80 mg/m²** x BSA = _________ mg
  - **Dose Modification:** _______% = _________ mg/m² x BSA = _________ mg
  - IV in 500 mL NS with 20 mEq potassium chloride, 1 g magnesium sulfate, 30 g mannitol over 1 hour

- **capecitabine 1000 mg/m²** x BSA x (_______ %) = _________ mg PO bid with food x 14 days
  - (Total daily dose = 2000 mg/m²/day) (Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

- □ Return in three weeks for Doctor and Cycle _____
- □ Return in _____ weeks for Doctor and Cycle _____
- □ Last Cycle. Return in _____ week(s).

**CBC & diff, platelets, creatinine, sodium, potassium** prior to each cycle

If clinically indicated:

- **bilirubin**
- **ALT**
- **Alk Phos**
- **CEA**
- **CA 19-9**
- **SCC**
- **INR** weekly
- **INR** prior to each cycle

**Other tests:**

- □ Weekly Nursing Assessment for (specify concern): ________________
- **Consults:**
- **See general orders sheet for additional requests.**

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**