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: GIGAVCOXP

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** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, creatinine clearance greater than or equal to 50 mL/minute, creatinine less than or equal to 1.5 times the upper limit of normal *and* less than or equal to 1.5 times the baseline, ALT less than or equal to 3 times the upper limit of normal, total bilirubin less than or equal to 1.5 times the upper limit of normal**

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 pembrolizumab infusion reaction:
- ☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to pembrolizumab
- ☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to pembrolizumab
- ☐ **hydrocortisone 25 mg** IV 30 minutes prior to pembrolizumab

☐ 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)

For patients with prior pembrolizumab and oxaliplatin reaction, administer oxaliplatin premedications prior to pembrolizumab

NO ice chips

☐ **Other:**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

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DATE:

**** Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT: ☐ **Repeat in three weeks**

pembrolizumab line to be primed with NS; oxaliplatin line to be primed with D5W

pembrolizumab 2 mg/kg x _____ kg = _____ mg **(max. 200 mg)**
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

oxaliplatin 130 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post dose.

For moderate vascular pain during peripheral administration:
250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn
OR ☐ 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn

capecitabine 1000 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO BID x 14 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book treatment x 2 cycles
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH prior to each cycle

If clinically indicated:

☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **chest x-ray**
☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **creatine kinase** ☐ **troponin**
☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**
☐ **serum HCG or** ☐ **urine HCG** – required for woman of childbearing potential
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Weekly nursing assessment**
☐ **Other consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: