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 and according to acceptable standards of care

PROTOCOL CODE: GIGAVCOXT

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 #:**

Date of Previous Cycle:

☐ Delay treatment ______ week(s)

☐ **CBC & diff, platelets, creatinine** 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, and Creatinine Clearance greater than or equal to 50 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 __________________________.

ondansetron 8 mg prior to chemotherapy

dexamethasone 8 mg or **12 mg** (circle one) prior to chemotherapy

NO ice chips

☐ **Other:**

CHEMOTHERAPY: ☐ **Repeat in three weeks**

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

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

☐ RN to administer 250 to 1000 mL D5W concurrently with oxaliplatin infusion, titrated to reduce phlebitis discomfort for patient

☐ **Cycle 1 Only:**

trastuzumab 8 mg/kg x _______ kg =__________mg IV in 250 mL NS over 1 hour 30 minutes.

Observe for 1 hour post infusion**

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

☐ **Cycle 2**

trastuzumab 6 mg/kg x _______ kg =______mg IV in 250 mL NS over 1 hour every three weeks x ______Cycle(s)

Observe for 30 minutes post infusion**

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE: **To be given:** **Cycle #:**

CHEMOTHERAPY: ☐ **Repeat in three weeks**

☐ **Cycle 3 and Subsequent:**

trastuzumab 6 mg/kg x ____ kg =______mg IV in 250 mL NS over 30 minutes every three weeks x ______Cycle(s)
Observe for 30 minutes post infusion**.

**Observation period not required after 3 treatments with no reaction

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

acetaminophen 325 to **650 mg** PO PRN for headache and rigors

capecitabine 1000 mg/m² 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 chemo x 2 cycles
☐ Last Cycle. Return in **three** weeks for **GIGAVTR** (to continue single agent trastuzumab)

CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Sodium, Potassium, Magnesium, Calcium prior to each cycle

☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **ECG** ☐ **CEA** ☐ **CA 19-9**
☐ **Other tests:** ☐ **MUGA scan or** ☐ **Echocardiogram**
☐ **Radiologic evaluation**
☐ **Weekly Nursing Assessment for (specify concern):** ______________________
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: