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, 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 treatment
dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) 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: ☐ **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

For moderate vascular pain during oxaliplatin 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

☐ **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 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:

DATE:

TREATMENT: ☐ **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 treatment x 2 cycles
☐ Last Cycle. Return in **three** weeks for **GIGAVTR** (to continue single agent trastuzumab)

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle
If clinically indicated:

☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **MUGA scan** or ☐ **echocardiogram**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Radiologic evaluation**
☐ **Weekly nursing assessment for (specify concern): _____**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: