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: GIGAVCOX

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**

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: All lines to be primed with D5W ☐ **Repeat in three weeks**
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

capecitabine 1000 mg/m^2 or _____ x BSA x (_____%) = _____ mg PO bid with food 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, total bilirubin, ALT prior to each cycle
If clinically indicated:
☐ **CEA** ☐ **CA 19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **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: