**PROTOCOL CODE: GIGAVFFOXN**



## DOCTOR'S ORDERS

**Ht**_____**cm** **Wt**_____**kg** **BSA**_____**m²**

**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

Day 1: May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.2 x $10^9$/L, platelets greater than or equal to 75 x $10^9$/L, 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, creatinine less than or equal to 1.5 times the upper limit of normal *and* less than or equal to 1.5 x baseline**.

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

☐ 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 nivolumab and oxaliplatin reaction, administer oxaliplatin premedications prior to nivolumab

**NO ice chips**

☐ **Other:**

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

## TREATMENT: (Note – continued over 2 pages)

☐ **Repeat in two weeks** ☐ **Repeat in two and in four weeks**

nivolumab line to be primed with NS; oxaliplatin and leucovorin lines to be primed with D5W

**nivolumab 3 mg/kg** x **_____kg** = _____ mg **(max. 240 mg)**
IV in 50 to 100 mL NS over 30 minutes using a 0.2 micron in-line filter.

**oxaliplatin 85 mg/m²** x BSA = _____mg
☐ Dose Modification: _____mg/m² x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours*. Flush line with D5W pre and post dose.

****CONTINUED ON PAGE 2****

| **DOCTOR'S SIGNATURE:** | **SIGNATURE:**<br><br>**UC:** |
|---|---|

**DATE:**

**TREATMENT: (Continued)**

**leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted)**

☐ **leucovorin 400 mg/m²** x BSA = _____ mg IV in 250 mL D5W over 2 hours*
*oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site

**OR**

☐ **leucovorin 20 mg/m²** x BSA = _____ mg IV push

**flourouracil**

**IV push (optional)**

☐ **fluorouracil 400 mg/m²** x BSA = _____ mg
☐ Dose Modification: _____mg/m² x BSA = _____mg
IV push **THEN**

**Infusion (required)**

**fluorouracil 2400 mg/m²** x BSA = _____ mg**
☐ Dose Modification: _____mg/m² x BSA = _____mg**
IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR

** For 3000 to 5500 mg dose **select INFUSOR per dose range below (doses outside** dose banding range are **prepared as ordered**):

| Dose Banding Range | Dose Band INFUSOR (mg) | Pharmacist Initial and Date |
|---|---|---|
| Less than 3000 mg | Pharmacy to mix specific dose | |
| 3000 to 3400 mg | 3200 mg | |
| 3401 to 3800 mg | 3600 mg | |
| 3801 to 4200 mg | 4000 mg | |
| 4201 to 4600 mg | 4400 mg | |
| 4601 to 5000 mg | 4800 mg | |
| 5001 to 5500 mg | 5250 mg | |
| Greater than 5500 mg | Pharmacy to mix specific dose | |

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**

**DATE:**

## RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and Cycle _____

☐ Return in **four** weeks for Doctor and Cycles _____&_____. Book treatment x 2 cycles

☐ Return in **six** weeks for Doctor and Cycles ____, ____ & ____. Book treatment x 3 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**

☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **creatine kinase** ☐ **troponin**

☐ **free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **random glucose**

☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH**

☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **Book for PICC assessment / insertion per Centre process**

☐ **Book for IVAD insertion per Centre process**

☐ **Weekly nursing assessment**

☐ **Other consults:**

☐ **See general orders sheet for additional requests.**

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**