

**PROTOCOL CODE: GIGAVFFOXP**

Page 1 of 3

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>
<b>REMINDER:</b> Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form		
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle(s) #:</b>
Date of Previous Cycle:		
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment		
Day 1: May proceed with doses as written if within 72 hours <b>ANC greater than or equal to <math>1.2 \times 10^9/L</math>, platelets greater than or equal to <math>75 \times 10^9/L</math>, 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.</b>		
Days 15 and 29: May proceed with doses as written if within 72 hours <b>ANC greater than or equal to <math>1.2 \times 10^9/L</math>, Platelets greater than or equal to <math>75 \times 10^9/L</math>.</b>		
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____		
<b>Proceed with treatment based on blood work from _____</b>		
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO prior to treatment dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO prior to treatment (omit if below dexamethasone IV premedication ordered) For prior pembrolizumab infusion reaction: <input type="checkbox"/> diphenhydramine 50 mg PO 30 minutes prior to pembrolizumab <input type="checkbox"/> acetaminophen 325 to 975 mg PO 30 minutes prior to pembrolizumab <input type="checkbox"/> hydrocortisone 25 mg IV 30 minutes prior to pembrolizumab <input type="checkbox"/> 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 <input type="checkbox"/> Other: _____		
<b>** Have Hypersensitivity Reaction Tray &amp; Protocol Available**</b>		
<b>TREATMENT: (Note – continued over 2 pages)</b> pembrolizumab line to be primed with NS; oxaliplatin and leucovorin lines to be primed with D5W pembrolizumab 4 mg/kg x _____ kg = _____ mg (max. 400 mg) IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter on <b>Day 1</b> oxaliplatin 85 mg/m <sup>2</sup> x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m <sup>2</sup> x BSA = _____ mg IV in 250 to 500 mL D5W over 2 hours* on <b>Days 1, 15 and 29</b> . Flush line with D5W pre and post dose.		
<b>**CONTINUED ON PAGE 2**</b>		
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>
		<b>UC:</b>

**PROTOCOL CODE: GIGAVFFOXP**

Page 2 of 3

**DATE:**

**TREATMENT: (Continued)**

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

- ☐ **leucovorin 400 mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg IV in 250 mL D5W over 2 hours\* on Days 1, 15 and 29**  
\*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/m<sup>2</sup> x BSA = \_\_\_\_\_ mg**  
IV push on **Days 1, 15 and 29**

**fluorouracil**

**IV push (optional)**

- ☐ **fluorouracil 400 mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg**  
☐ Dose Modification: \_\_\_\_\_ mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg  
IV push on **Days 1, 15 and 29, THEN**

**Infusion (required)**

**fluorouracil 2400 mg/m<sup>2</sup> x BSA = \_\_\_\_\_ mg\*\***

- ☐ Dose Modification: \_\_\_\_\_ mg/m<sup>2</sup> 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 on **Days 1, 15 and 29**

\*\* 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:**

**PROTOCOL CODE: GIGAVFFOXP**

Page 3 of 3

<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>six</b> weeks for Doctor and for Cycle _____. Book <b>treatment</b> on Days 1, 15, and 29 <input type="checkbox"/> Return in _____ weeks for Doctor assessment <input type="checkbox"/> Last Cycle. Return in _____ week(s)	
<p><b>CBC &amp; Diff, creatinine, ALT, total bilirubin, sodium, potassium, TSH</b> prior to Day 1 of each cycle</p> <p><b>CBC &amp; Diff, creatinine, total bilirubin, ALT</b> on Days 15 and 29 of each cycle</p> <p>If clinically indicated: <input type="checkbox"/> <b>CEA</b> <input type="checkbox"/> <b>CA 19-9</b> <input type="checkbox"/> <b>ECG</b> <input type="checkbox"/> <b>chest x-ray</b></p> <p><input type="checkbox"/> <b>free T3 and free T4</b> <input type="checkbox"/> <b>lipase</b> <input type="checkbox"/> <b>morning serum cortisol</b> <input type="checkbox"/> <b>random glucose</b></p> <p><input type="checkbox"/> <b>alkaline phosphatase</b> <input type="checkbox"/> <b>albumin</b> <input type="checkbox"/> <b>GGT</b> <input type="checkbox"/> <b>creatine kinase</b> <input type="checkbox"/> <b>troponin</b></p> <p><input type="checkbox"/> <b>serum ACTH levels</b> <input type="checkbox"/> <b>testosterone</b> <input type="checkbox"/> <b>estradiol</b> <input type="checkbox"/> <b>FSH</b> <input type="checkbox"/> <b>LH</b></p> <p><input type="checkbox"/> <b>serum HCG</b> or <input type="checkbox"/> <b>urine HCG</b> – required for woman of childbearing potential</p> <p><input type="checkbox"/> <b>INR</b> weekly <input type="checkbox"/> <b>INR</b> prior to each cycle</p> <p><input type="checkbox"/> <b>Book for PICC assessment / insertion per Centre process</b></p> <p><input type="checkbox"/> <b>Book for IVAD insertion per Centre process</b></p> <p><input type="checkbox"/> <b>Weekly nursing assessment</b></p> <p><input type="checkbox"/> <b>Other consults:</b></p> <p><input type="checkbox"/> <b>See general orders sheet for additional requests.</b></p>	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>  <b>UC:</b>