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, Platelets day of treatment

May proceed with doses as written if within 72 hours ANC greater than or equal to 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L

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 (circle one) PO prior to treatment
NO ice chips
☐ Other:

CHEMOTHERAPY: (Note – continued over 2 pages)

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

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

oxaliplatin 85 mg/m² x BSA = _______ mg
☐ Dose Modification: _______ mg/m² x BSA = _______ mg
IV in 250 to 500 mL D5W over 2 hours*

leucovorin 400 mg/m² x BSA = _______ mg IV in 250 mL D5W over 2 hours*
xoxaliplatin 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

fluorouracil 400 mg/m² x BSA = _______ mg
☐ Dose Modification: _______ mg/m² x BSA = _______ mg
IV push

☐ Cycle 1 Only:
trastuzumab (HERCEPTIN) 6 mg/kg x _______ kg = _______ mg IV in 250 mL NS over 1 hour 30 minutes.
Observe for 1 hour post infusion**

OR
☐ Cycle 2
trastuzumab (HERCEPTIN) 4 mg/kg x _______ kg = _______ mg IV in 250 mL NS over 1 hour every two weeks x _______ Cycle(s) Observe for 30 minutes post infusion**

*** SEE PAGE 2 FOR FLUOROURACIL INFUSIONAL CHEMOTHERAPY ***

DOCTOR'S SIGNATURE:  SIGNATURE:

BC Cancer Provincial Preprinted Order GIGAVFFOXT
Created: 1 Feb 2019  Revised: 1 May 2019
**CHEMOTHERAPY: (Continued)**

- **Cycle 3 and Subsequent:**
  - trastuzumab (HERCEPTIN) 4 mg/kg x ____ kg = ____ mg IV in 250 mL NS over 30 minutes every two weeks x ______Cycle(s)  
  - **Observation period not required after 3 treatments with no reaction**
  - acetaminophen 325 to 650 mg PO PRN for headache and rigors

- **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):**

<table>
<thead>
<tr>
<th>Dose Banding Range</th>
<th>Dose Band INFUSOR (mg)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3000 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
<tr>
<td>3000 to 3400 mg</td>
<td>3200 mg</td>
<td></td>
</tr>
<tr>
<td>3401 to 3800 mg</td>
<td>3600 mg</td>
<td></td>
</tr>
<tr>
<td>3801 to 4200 mg</td>
<td>4000 mg</td>
<td></td>
</tr>
<tr>
<td>4201 to 4600 mg</td>
<td>4400 mg</td>
<td></td>
</tr>
<tr>
<td>4601 to 5000 mg</td>
<td>4800 mg</td>
<td></td>
</tr>
<tr>
<td>5001 to 5500 mg</td>
<td>5250 mg</td>
<td></td>
</tr>
<tr>
<td>Greater than 5500 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
</tbody>
</table>

**RETURN APPOINTMENT ORDERS**

- Return in **two** weeks for Doctor and Cycle _____
- Return in **four** weeks for Doctor and Cycles _____ & ____. Book chemo x 2 cycles
- Return in **six** weeks for Doctor and Cycles ____, ____, & _____. Book chemo x 3 cycles
- Last Cycle. Return in two weeks for GIGAVTR (to continue single agent trastuzumab) – note GIGAVTR protocol is every three weeks.

- **CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca** prior to each cycle
- **INR** weekly  
- **ECG**  
- **CEA**  
- **CA 19-9**  
- **Other tests:**  
- MUGA scan or Echocardiogram
- **Book for PICC assessment / insertion per Centre process**
- **Book for IVAD insertion per Centre process**
- **Weekly Nursing Assessment for (specify concern):** ______________________
- **Consults:**
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**