**DOCTOR'S ORDERS**

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**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 $1.2 \times 10^9$/L, Platelets greater than or equal to $75 \times 10^9$/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 (select one) PO prior to treatment

- NO ice chips

**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** $85 \text{ mg/m}^2 \times \text{BSA} = _______ \text{mg}$
  
  ☐ Dose Modification: _______ \text{mg/m}^2 \times \text{BSA} = _______ \text{mg}

  IV in 250 to 500 mL D5W over 2 hours*

- **leucovorin** 400 mg/m² \times \text{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 \times \text{BSA} = ______ mg

  IV push

- **fluorouracil** 400 mg/m² \times \text{BSA} = ______ mg

  ☐ Dose Modification: _______ \text{mg/m}^2 \times \text{BSA} = _______ \text{mg}

  IV push

- **Cycle 1 Only:**

  - **trastuzumab** 6 mg/kg \times ______ 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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>trastuzumab</td>
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</table>

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

**DOCTOR'S SIGNATURE:** __________________________

**SIGNATURE:** __________________________

**UC:** GIGAVFFOXT

Created: 1 Feb 2019

Revised: 1 Nov 2020
DATE:                                                       To be given:                                                Cycle(s) #:

CHEMOTHERAPY:   (Note – continued over 2 pages)
☐ Repeat in two weeks       ☐ Repeat in two and in four weeks
☐ Cycle 2
  trastuzumab  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**
  Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

<table>
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<tr>
<td>trastuzumab</td>
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☐ Cycle 3 and Subsequent:
  trastuzumab  4 mg/kg x ____ kg =______mg IV in 250 mL NS over 30 minutes every two 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

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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>
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</tbody>
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DOCTOR'S SIGNATURE:                        SIGNATURE:

BC Cancer Provincial Preprinted Order GIGAVFFOXT
Created:  1 Feb 2019                    Revised:  1 Nov 2020
**DATE:**

**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   [ ] INR prior to each cycle
- [ ] 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:**

**UC:**