PROTOCOL CODE: GIGAVFFOXT

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 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**

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: (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/m^2 x BSA = _____mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours*

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

☐ **leucovorin 400 mg/m^2** 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/m^2** x BSA = _____ mg
IV push

*** CONTINUED ON PAGE 2 ***

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

DATE:

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

TREATMENT: (Continued)

flourouracil IV push (optional)

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

☐ **Cycle 1 Only:**
trastuzumab 6 mg/kg x _____ 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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

☐ **Cycle 2**
trastuzumab 4 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour
Observe for 30 minutes post infusion**

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

☐ **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

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

acetaminophen 325 to **650 mg** PO PRN for headache and rigors

flourouracil 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 two weeks for **GIGAVTR** (to continue single agent trastuzumab) – note GIGAVTR protocol is every three weeks.	
CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle If clinically indicated: ☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **MUGA scan** or ☐ **echocardiogram** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **Other tests:** ☐ **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:**