# PROTOCOL CODE: GIGAVRAMT



## 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 #:**

Date of Previous Cycle:

☐ Delay Treatment _____ week(s)

☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 24 hours **ANC greater than or equal to 1.5 x $10^9$/L, platelets greater than or equal to 100 x $10^9$/L (ramucirumab days: BP less than or equal to 160/100, and urine dipstick negative or +1)**

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity**_____

**Proceed with treatment based on blood work from** _____

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm _____.

**45 minutes prior to Treatment:**

**dexamethasone 10 mg** IV in 50 mL NS over 15 minutes.

**30 minutes prior to Treatment:**

**diphenhydrAMINE 25 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 pre-medication required for PACLitaxel.

**If PACLitaxel not given or no pre-medication required for PACLitaxel give:**

**diphenhydrAMINE 25 mg** IV prior to **ramucirumab**.

☐ **Other:**

****Have Hypersensitivity Reaction Tray and Protocol Available****

**TREATMENT**: ***Use a separate infusion line and filter for each drug.***

**ramucirumab 8 mg/kg** x _____ kg = _____ mg on **Days 1 and 15**

☐ Dose Modification: _____ mg/kg x _____ kg = _____ mg

IV in 250 to 500 mL NS over 1 hour to 1 hour 30 min (use 0.2 micron in-line filter)

(Blood pressure measurement pre and post doses for first 3 cycles and prior to **ramucirumab** for subsequent cycles)

**PACLitaxel 80 mg/$m^2$** x BSA = _____mg on **Days 1, 8 and 15**

☐ Dose Modification: _____ mg/$m^2$ x BSA = _____ mg

IV in 100 mL to 250 mL (use non-DEHP bag) NS over 1 hour

(Use non-DEHP tubing with 0.2 micron in-line filter)

**ADDITIONAL DOSE MODIFICATION IF REQUIRED:** ***Use a separate infusion line and filter for each drug.***

**ramucirumab _____ mg/kg** x _____ kg = _____ mg IV in 250 to 500 mL NS over 1 hour to 1 hour 30 min (use 0.2 micron in-line filter)

(Blood pressure measurement pre and post doses for first 3 cycles and prior to **ramucirumab** for subsequent cycles)

**PACLitaxel** _____ **mg/$m^2$** x BSA = _____mg

IV in 100 mL to 250 mL (use non- DEHP bag) NS over 1 hour

(Use non-DEHP tubing with 0.2 micron in-line filter)

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

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## RETURN APPOINTMENT ORDERS

☐ Return in **four** weeks for Doctor and Cycle _____. Book chemo weekly x 3 weeks.

☐ Last Cycle. Return in _____weeks from last treatment.

Prior to Days 1, 8, and 15: **CBC & Diff**

Prior to Day 1 and Day 15: **creatinine, total bilirubin, ALT, Dipstick urine or laboratory urinalysis for protein**

(If results are 2+ or higher, or greater than or equal to 1 g/L laboratory urinalysis for protein, then:

☐ **24 hr urine for total protein** must be done within 3 days prior to next cycle.)

If clinically indicated:

☐ **CEA** ☐ **CA 19-9** ☐ **ECG**

☐ **TSH** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium**

☐ **potassium**

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

☐ **Other tests:**

☐ **Consults:**

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

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**SIGNATURE:**

**UC:**