PROTOCOL CODE: GIGAVTRFT

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, Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 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 _____

CHEMOTHERAPY: ☐ **Repeat in 4 weeks**

trifluridine-tipiracil 35 mg/m^2 x BSA = _____ mg PO *twice* daily on days 1-5 and 8-12 of each 28 days cycle.
Round dose to nearest 5 mg. **Maximum 80 mg/dose; based on trifluridine component**

Dose modification :

☐ **trifluridine-tipiracil 30 mg/m^2** x BSA = _____ mg PO *twice* daily on days 1-5 and 8-12 of each 28 days cycle
(dose level -1) Supply for:_____ days.

☐ **trifluridine-tipiracil 25 mg/m^2** x BSA = _____ mg PO *twice* daily on days 1-5 and 8-12 of each 28 days cycle
(dose level -2) Supply for:_____ days.

☐ **trifluridine-tipiracil 20 mg/m^2** x BSA = _____ mg PO *twice* daily on days 1-5 and 8-12 of each 28 days cycle
(dose level -3) Supply for:_____ days.

☐ **trifluridine-tipiracil _____mg/m^2** x BSA = _____mg PO *twice* daily on days 1-5 and 8-12 of each 28 days cycle
Supply for:_____ days.
Round dose to nearest 5 mg. **Maximum 80 mg/dose; based on trifluridine component**

RETURN APPOINTMENT ORDERS

☐ Return in _____ weeks for Doctor and Cycle _____.
☐ Last Cycle. Return in _____ week(s).

CBC & diff, platelets, creatinine, sodium, potassium, urea, bilirubin, ALT, alkaline phosphatase, LDH prior to each cycle
CBC & diff, platelets prior to day 15

☐ **dipstick urine protein** ☐ **CEA** ☐ **CA 19-9**
☐ **ECG (if clinically indicated)**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: