PROTOCOL CODE: UGIFFOXPAN

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 (select one) PO prior to treatment
- NO ice chips
- □ Other:

☐ magnesium sulfate 2 g in 50 mL NS over 30 min for hypomagnesemia
☐ magnesium sulfate 5 g in 100 mL NS over 3 hours for hypomagnesemia

**Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY: (Note – continued over 2 pages)

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

PANitumumab 6 mg/kg x _______ kg = ________ mg

☐ Dose Modification: ____mg/kg x _______ kg = ________mg

IV in 100 mL NS over 1 hour. Use 0.22 micron in-line filter.

If tolerated, administer over 30 minutes in subsequent cycles. For doses greater than 1000 mg, use 150 mL NS and infuse over 1 hour 30 min each cycle. Flush lines with 25 mL NS pre and post PANitumumab infusion.

Prior to starting oxaliplatin, flush lines with D5W

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*

* 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 x BSA = ________ mg

IV push

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

DOCTOR’S SIGNATURE: SIGNATURE: UC:
Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: UGIFFOXPN

DATE:

CHEMOTHERAPY: (Continued)

fluorouracil 400 mg/m² x BSA = ________ mg

☐ Dose Modification: __________mg/m² x BSA = ________mg

IV push

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 ______ week(s).

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg and Ca prior to each cycle

☐ INR weekly  ☐ INR prior to each cycle

☐ ECG  ☐ CEA  ☐ CA 19-9

☐ 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:

Created: 1 Nov 2017  Revised: 9 Nov 2020