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 (circle one) PO prior to treatment

☐ 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 line to be primed with NS; oxaliplatin and leucovorin lines to be primed with D5W

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 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

fluorouracil 400 mg/m² x BSA = ________ mg

☐ Dose Modification: ________ mg/m² x BSA = ________ mg

IV push

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

DOCTOR’S SIGNATURE:  SIGNATURE:

UC:
DATE:

CHEMOTHERAPY: (Continued)
fluorouracil 2400 mg/m\(^2\) x BSA = _______ mg**

☐ Dose Modification: ___________mg/m\(^2\) 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: ____________________________