

PROTOCOL CODE: UGIGAVTRFT

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A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment

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 #:** _____

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 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 _____

CHEMOTHERAPY: Repeat in 4 weeks

trifluridine-tipiracil 35 mg/m² 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/m² 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/m² 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/m² 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/m² 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: _____