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: HNLACETRT

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:** **Day(s):**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ Day of treatment: CBC & Diff, platelets, magnesium, calcium, albumin, sodium, potassium, creatinine

Dose modification for: _____

Proceed with treatment based on bloodwork from _____

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

diphenhydrAMINE 50 mg PO 30 to 60 minutes prior to each cetuximab dose

☐ **hydrocortisone 100 mg** IV 30-60 minutes prior to each cetuximab dose

☐ **Other:**

Magnesium supplementation: (see protocol for magnesium supplementation guidelines)

☐ **magnesium sulfate 2 g** IV in 50 mL NS over 30 minutes

☐ **magnesium sulfate 5 g** IV in 100 mL NS over 3 hours

**** Have Hypersensitivity Reaction Tray and protocol available****

TREATMENT:

Vital signs pre-infusion, halfway through infusion and one hour post infusion.

Patients are to be observed visually for the first 15 minutes of cetuximab infusion.
Observe for 1 hour following end of 1st and 2nd infusions (Day minus 7 and Day 1).

May discontinue observation period and vital signs if no infusion reaction for 2 consecutive doses.

Day minus 7 from radiation start date**:**

cetuximab (first dose) 400 mg/m^2 X BSA = _____ mg
IV over 2 hours (use 0.2 micron in-line filter). Infusion rate not to exceed 10 mg/minute.

Concurrent with radiation therapy:

cetuximab (subsequent dose) 250 mg/m^2 X BSA = _____s_____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV over 1 hour (use 0.2 micron in-line filter) once weekly x ☐ 5 weeks or ☐ 7 weeks (select one).
Infusion rate not to exceed 10 mg/minute.

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

PROTOCOL CODE: HNLACETRT

DATE:	To be given:	Day(s):

RETURN APPOINTMENT ORDERS

Book weekly chemo for duration of RT X ☐ 5 weeks or ☐ 7 weeks (select one) Return in _____ weeks for Doctor and toxicity assessment ☐ Last Cycle. Return in _____ week(s).	
CBC & Diff, magnesium, calcium, albumin, sodium, potassium, phosphate, creatinine prior to each treatment **If clinically indicated:** ☐ **ALT** ☐ **HB viral load** ☐ **Tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**