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** day of treatment

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.2 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 _____

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

dexamethasone ☐ **8 mg** or ☐ **12 mg** *(select one)* PO prior to treatment (omit if below dexamethasone IV premedication ordered) and select ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1 and 80 mg on Day 2 and 3 **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment on Day 1 and 2
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment on Day 1

☐ For prior zolbetuximab infusion reaction:

diphenhydrAMINE 50 mg (select one) ☐ PO or ☐ IV 30 minutes prior to zolbetuximab

☐ For prior oxaliplatin hypersensitivity reactions (Grade 1 or 2):

45 minutes prior to oxaliplatin: **dexamethasone 20 mg** IV in 50 mL NS over 15 minutes

30 minutes prior to oxaliplatin: **diphenhydrAMINE 50 mg** IV in NS 50 mL over 15 minutes and **famotidine 20 mg** IV in NS 100 mL over 15 minutes (Y-site compatible)

NO ice chips

☐ **Other:**

metoclopramide 10 mg PO/IV Q4-6H PRN for nausea and vomiting during zolbetuximab infusion

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:

**** Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT:

☐ **CYCLE #1:**

DAY 1:
zolbetuximab 800 mg/m2 x BSA =_____mg
IV in 250 to 500 mL NS using 0.2 micron in-line filter. Start infusion at 75mg/m2/hour for 60 minutes. If no reaction after 60 minutes, increase to 150 mg/m^2/hour for 60 minutes, then increase to 300mg/m^2/hour for the remainder of the infusion. Refer to protocol appendix.1 for zolbetuximab infusion rate titration table. Vital signs pre- and post-infusion, at each increment change and as clinically indicated. Patient to be under constant visual observation during all rate increases. Observe for 2 hours post infusion.

DAY 2:
oxaliplatin 85 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV in 250 to 500 mL D5W over 2 hours*

leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted)

☐ **leucovorin 400 mg/m^2** 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/m^2** x BSA = _____ mg IV push

fluorouracil IV push (optional)

☐ **fluorouracil 400 mg/m^2** x BSA = _____ mg
☐ Dose Modification: _____mg/m^2 x BSA = _____mg
IV push **THEN**

fluorouracil infusion (required)

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

Pharmacist to select **dose band** per last page of PPO. Complete table below (Please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
fluorouracil		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:

**** Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT: (Continued): ☐ **Repeat in two weeks** ☐ **Repeat in two and in four weeks**

☐ **CYCLE #2 onward:**

DAY 1:

zolbetuximab 400 mg/m2 x BSA =_____mg

IV in 100 to 250 mL NS using 0.2 micron in-line filter. Start infusion at 75mg/m2/hour for 60 minutes. If no reaction after 60 minutes, increase to 150 mg/m^2/hour for 60 minutes, then increase to 300mg/m^2/hour for the remainder of the infusion. Refer to protocol appendix.1 for zolbetuximab infusion rate titration table. Vital signs pre- and post-infusion, at each increment change and as clinically indicated. Observe for 2 hours post infusion. If no reaction or Grade 1 reaction during previous infusion, observe for 1 hour post-infusion. If Grade 2 reaction during previous infusion, observe for 2 hours post-infusion.

Vital signs and observation may be discontinued after 3 treatments with no infusion-related reactions.

DAY 2:

oxaliplatin 85 mg/m^2 x BSA = _____mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV in 250 to 500 mL D5W over 2 hours*****

leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted)

☐ **leucovorin 400 mg/m^2** 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/m^2** x BSA = _____ mg IV push

fluorouracil IV push (optional)

☐ **fluorouracil 400 mg/m^2** x BSA = _____ mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV push **THEN**

fluorouracil infusion (required)

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

Pharmacist to select **dose band** per last page of PPO. Complete table below (Please print)

Drug	Dose Band (mg)	Pharmacist Initial and Date
fluorouracil		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

RETURN APPOINTMENT ORDERS	
☐ Return in **two** weeks for Doctor and Cycle _____ ☐ Return in **four** weeks for Doctor and Cycles _____&_____. Book treatment x 2 cycles ☐ Return in **six** weeks for Doctor and Cycles ____, ____ & ____. Book treatment x 3 cycles ☐ Last Cycle. Return in _____ week(s)	
CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle If clinically indicated: ☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **magnesium** ☐ **random glucose** ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **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:**

FLUOROURACIL DOSE BANDING TABLE

Ordered Dose (mg)		Rounded dose (mg) for INFUSOR
From:	**To:**	
Less than 3000		**Pharmacy prepares specific dose**
3000	3400	**3200 mg**
3401	3800	**3600 mg**
3801	4200	**4000 mg**
4201	4600	**4400 mg**
4601	5000	**4800 mg**
5001	5500	**5250 mg**
More than 5500		**Pharmacy prepares specific dose**