PROTOCOL CODE: GIRNACOX

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:** **Cycle(s) #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, platelets greater than or equal to 75 x 10^9/L, creatinine clearance greater than 50 mL/minute**

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 (omit if below dexamethasone IV premedication ordered)

☐ 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:**

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

TREATMENT: All lines to be primed with D5W ☐ **Repeat in three weeks**

oxaliplatin 130 mg/m^2 x BSA = _____ mg
☐ Dose Modification: _____ mg/m^2 x BSA = _____ mg
IV in 250 to 500 mL D5W over 2 hours

For moderate vascular pain during oxaliplatin peripheral administration
250 mL D5W at maximum rate of 125 mL/h concurrently with oxaliplatin prn
OR ☐ 500 mL D5W at maximum rate of 250 mL/h concurrently with oxaliplatin prn

capecitabine 1000 mg/m^2 or _____ x BSA x (_____ %) = _____ mg PO BID x 14 days

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

Drug	Dose Band (mg)	Pharmacist Initial and Date
capecitabine		

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book treatment x 2 cycles.
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle

If clinically indicated:
☐ **CEA** ☐ **CA19-9** ☐ **ECG**
☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Weekly nursing assessment for (specify concern):** _____
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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CAPECITABINE DOSE BANDING TABLE

Ordered Dose (mg)		Rounded dose (mg)	Number of Tablets Per Dose	
From:	To:		150 mg	500 mg
226	375	300	2	
376	475	450	3	
476	575	500		1
576	725	650	1	1
726	900	800	2	1
901	1075	1000		2
1076	1225	1150	1	2
1226	1400	1300	2	2
1401	1575	1500		3
1576	1725	1650	1	3
1726	1900	1800	2	3
1901	2075	2000		4
2076	2225	2150	1	4
2226	2400	2300	2	4
2401	2575	2500		5
2576	2725	2650	1	5
2726	2900	2800	2	5
2901	3075	3000		6
3076	3225	3150	1	6
3226	3400	3300	2	6
3401	3575	3500		7
3576	3725	3650	1	7
3726	3900	3800	2	7