



Provincial Health Services Authority

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: SMAVCET

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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: _____				
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> Day of treatment: CBC & diff, platelets, magnesium, calcium, albumin, electrolytes, creatinine May proceed with doses as written if less than Grade 2: rash, diarrhea, stomatitis Dose modification for: <input type="checkbox"/> Severe acneiform rash <input type="checkbox"/> diarrhea <input type="checkbox"/> stomatitis 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 <input type="checkbox"/> Other: _____				
** Have Hypersensitivity Reaction Tray and protocol available**				
TREATMENT:				
VITAL SIGNS: Temperature, Pulse, Respiration, Blood Pressure pre -cetuximab infusion, halfway through infusion and one hour post infusion.* Patients are to be observed visually for the first 15 minutes of cetuximab infusion. Flush cetuximab line post infusion with Normal Saline (0.9% Sodium Chloride Injection)				
Cycle 1:				
cetuximab 400 mg/m² X BSA = _____ mg IV over 2 hours (infusion rate not to exceed 10 mg/minute) using 0.2 micron in-line filter. Flush cetuximab line post infusion with NS. Observe for 1 hour post-infusion.				
Cycle 2 and onwards: <input type="checkbox"/> Repeat in one week <input type="checkbox"/> Repeat in one and two weeks cetuximab 250 mg/m² X BSA = _____ mg <input type="checkbox"/> Dose Modification _____ % = _____ mg/m ² x BSA = _____ mg IV over 1 hour (infusion rate not to exceed 10 mg/minute) using 0.2 micron in-line filter. Flush cetuximab line post infusion with NS. Observe for 1 hour post-infusion (may discontinue observation period and vital signs if no infusion reaction for 2 consecutive doses).				
POST-TREATMENT Magnesium Supplementation: (see protocol for magnesium supplementation guidelines)				
<input type="checkbox"/> magnesium sulfate 2 G IV in 50 mL NS over 30 minutes <input type="checkbox"/> magnesium sulfate 5 G IV in 100 mL NS over 3 hours				
RETURN APPOINTMENT ORDERS				
Return in one week for Doctor and Cycle _____ Return in two weeks for Doctor and Cycles _____ & _____. Book chemo x 2 cycles Return in three weeks for Doctor and Cycles _____ & _____ & _____. Book chemo x 3 cycles <input type="checkbox"/> Last Cycle. Return in _____ week(s)				
Prior to each cycle: CBC & diff, platelets, magnesium, calcium, albumin, sodium, potassium, creatinine <input type="checkbox"/> Tests: _____ <input type="checkbox"/> Consults: _____ <input type="checkbox"/> See general orders sheet for additional requests.				
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC: