BC CANCER
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: GIGAVFFOXT

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, Platelets** 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 __________________________.
ondansetron 8 mg PO prior to treatment
dexamethasone ☐ **8 mg** or ☐ **12 mg** (*select one*) PO prior to treatment
NO ice chips
☐ **Other:**

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **Repeat in two weeks** ☐ **Repeat in two and in four weeks**

oxaliplatin and leucovorin lines to be primed with D5W; trastuzumab line to be primed with NS.

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 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 400 mg/m^2 x BSA = ______ mg
☐ Dose Modification: ___________mg/m^2 x BSA = _________mg
IV push

☐ **Cycle 1 Only:**
trastuzumab 6 mg/kg x _______ kg =__________mg IV in 250 mL NS over 1 hour 30 minutes.
Observe for 1 hour post infusion**

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

***** SEE PAGE 2 FOR FLUOROURACIL INFUSIONAL CHEMOTHERAPY *****

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE: **To be given:** **Cycle(s) #:**

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **Repeat in two weeks** ☐ **Repeat in two and in four weeks**

☐ **Cycle 2**

trastuzumab 4 mg/kg x _______ kg =______mg IV in 250 mL NS over 1 hour every two weeks x ______Cycle(s)
Observe for 30 minutes post infusion**

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

☐ **Cycle 3 and Subsequent:**

trastuzumab 4 mg/kg x ____ kg =______mg IV in 250 mL NS over 30 minutes every two weeks x ______Cycle(s)
Observe for 30 minutes post infusion**.

**Observation period not required after 3 treatments with no reaction

Pharmacy to select trastuzumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
trastuzumab		

acetaminophen 325 to **650 mg** PO PRN for headache and rigors

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

** For 3000 to 5500 mg dose **select INFUSOR per dose range below (doses outside** dose banding range are **prepared as ordered**):

Dose Banding Range	Dose Band INFUSOR (mg)	Pharmacist Initial and Date
Less than 3000 mg	Pharmacy to mix specific dose	
3000 to 3400 mg	3200 mg	
3401 to 3800 mg	3600 mg	
3801 to 4200 mg	4000 mg	
4201 to 4600 mg	4400 mg	
4601 to 5000 mg	4800 mg	
5001 to 5500 mg	5250 mg	
Greater than 5500 mg	Pharmacy to mix specific dose	

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **two** weeks for Doctor and Cycle ______ ☐ Return in **four** weeks for Doctor and Cycles _____&_____. Book chemo x 2 cycles ☐ Return in **six** weeks for Doctor and Cycles ____, ____ & ____. Book chemo x 3 cycles ☐ Last Cycle. Return in two weeks for **GIGAVTR** (to continue single agent trastuzumab) – note GIGAVTR protocol is every three weeks.	
CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca prior to each cycle ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **ECG** ☐ **CEA** ☐ **CA 19-9** ☐ **Other tests:** ☐ **MUGA scan or** ☐ **Echocardiogram** ☐ **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:**