PROTOCOL CODE: HNLACETRT

DOCTOR'S ORDERS

Height_____cm Weight_____kg BSA = $\sqrt{\frac{\text{Height (cm x Weight (kg)}}{3600}}$ = _____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, electrolytes, creatinine

May proceed with doses as written if less than Grade 2: rash, diarrhea, stomatitis

Dose modification for: ☐ Severe acneiform rash ☐ diarrhea ☐ stomatitis

Rate modification for: ☐ Allergic/Hypersensitivity reactions

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

☐ **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)

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.

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.

Concurrent on days with Radiation Therapy weekly X ☐ 2 weeks OR ☐ 3 weeks (select one)

cetuximab (subsequent dose) 250 mg/m^2 X BSA = _____ mg IV over 1 hour (use 0.2 micron in-line filter)
(Observation period during RT)

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

☐ Decrease infusion rate by 50% for previous allergic/hypersensitivity reaction.

Start time of observation: _____

End time of observation: _____

POST-CHEMO 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

RN to assess for severe acneiform rash and diarrhea prior to EACH cetuximab infusion
Notify Doctor of any signs and symptoms of toxicity prior to administering cetuximab

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 _____ weeks Return in _____ weeks for Doctor ☐ Last Cycle. Return in _____ week(s).	
CBC & diff, platelets, magnesium, calcium, albumin, sodium, potassium, creatinine, prior to next physician appointment ☐ re-check magnesium level in 1 week **OR** ☐ patient will be seen in Patient Review and lab work to be ordered as below: **Day 22**: **CBC & diff, platelets, magnesium, calcium, albumin, sodium, potassium, creatinine** **Day 36: CBC & diff, platelets, magnesium, calcium, albumin, sodium, potassium, creatinine** ☐ **Tests:** ☐ **Consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**