PROTOCOL CODE: GIGAVCFT

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 #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, Platelets, Creatinine** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.5 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L, and Creatinine Clearance greater than or equal to 60 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 _____.

dexamethasone 8 mg PO 30 to 60 minutes prior to chemotherapy

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to chemotherapy **ondansetron 8 mg** PO 30 to 60 minutes prior to chemotherapy
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to chemotherapy

☐ **Other:**

PRE-HYDRATION: 1000 mL NS over 1 hour pre-CISplatin

CHEMOTHERAPY:

CISplatin 80 mg/m^2 x BSA = _____ mg

☐ Dose Modification: _____% = _____ mg/m^2 x BSA = _____ mg

IV in 500 mL NS with 20 mEq potassium chloride, 1 g magnesium sulfate, 30 g mannitol over 1 hour

☐ **Cycle 1 Only:**

trastuzumab 8 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		

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

fluorouracil 800 mg/m^2/day x BSA = _____mg/day for 5 days (total dose for each 5 day infusor = _____ mg over 120 h)

☐ Dose Modification:_____% = _____ mg/m^2/day x BSA = _____ mg**/day** for 5 days (total dose for each 5 day infusor =_____ mg over 120 h)

IV in D5W to a total volume of 240 mL by continuous infusion at 2 mL/h via Baxter LV2 infusor.

(Total dose = 4000 mg/m^2 over 120 hours)

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

DATE: **To be given:** **Cycle #:**

CHEMOTHERAPY:

☐ **Cycle 2**

trastuzumab 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 1 hour every three 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 6 mg/kg x _____ kg =_____mg IV in 250 mL NS over 30 minutes every three 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 800 mg/m^2/day x BSA = _____mg/day for 5 days (total dose for each 5 day infusor = _____ mg over 120 h)

☐ Dose Modification:_____% = _____ mg/m^2/day x BSA = _____ mg**/day** for 5 days (total dose for each 5 day infusor =_____ mg over 120 h)

IV in D5W to a total volume of 240 mL by continuous infusion at 2 mL/h via Baxter LV2 infusor.
(Total dose = 4000 mg/m^2 over 120 hours)

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle _____ ☐ Return in _____ weeks for Doctor and Cycle _____ ☐ Last Cycle. Return in **three** weeks for **GIGAVTR** (to continue single agent trastuzumab)	
CBC & Diff, Platelets, Creatinine, Sodium, Potassium prior to each cycle If clinically Indicated: ☐ **Bilirubin** ☐ **ALT** ☐ **Alk Phos** ☐ **MUGA scan or** ☐ **Echocardiogram** ☐ **ECG** ☐ **CEA** ☐ **CA 19-9** ☐ **Radiologic evaluation** ☐ **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:**