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: GIGAVCOXP

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 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 or equal to 50 mL/minute, creatinine less than or equal to 1.5 times the upper limit of normal *and* less than or equal to 1.5 times the baseline, ALT less than or equal to 3 times the upper limit of normal, bilirubin less than or equal to 1.5 times the upper limit of normal**

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** *(circle one)* PO prior to treatment

NO ice chips

For prior pembrolizumab infusion reaction:

☐ **diphenhydrAMINE 50 mg** PO 30 minutes prior to treatment
☐ **acetaminophen 325 to 975 mg** PO 30 minutes prior to treatment
☐ **hydrocortisone 25 mg** IV 30 minutes prior to treatment

☐ **Other:**

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

CHEMOTHERAPY: ☐ **Repeat in three weeks**

pembrolizumab line to be primed with NS; oxaliplatin line to be primed with D5W

pembrolizumab 2 mg/kg x ________ kg = __________ mg **(max. 200 mg)**
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter

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. Flush line with 25 mL D5W pre and post dose.

To reduce incidence of vascular pain:
☐ 250 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 125 mL/h
☐ 500 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 250 mL/h

capecitabine 1000 mg/m^2 or ______ x BSA x (_______%) = ________ mg PO BID x 14 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

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

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: GIGAVCOXP

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **three** weeks for Doctor and Cycle __________ ☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles ☐ Last Cycle. Return in _________ week(s)	
CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, magnesium, calcium, TSH prior to each cycle If clinically indicated: ☐ **CEA** ☐ **CA 19-9** ☐ **ECG** ☐ **Chest X-ray *or*** ☐ **CT Chest** ☐ **Free T3 and free T4** ☐ **lipase** ☐ **morning serum cortisol** ☐ **Glucose** ☐ **serum ACTH levels** ☐ **testosterone** ☐ **estradiol** ☐ **FSH** ☐ **LH** ☐ **serum HCG or** ☐ **urine HCG** – required for woman of child bearing potential ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **Radiologic evaluation** ☐ **Weekly nursing assessment** ☐ **Other consults:** ☐ **See general orders sheet for additional requests.**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**