PROTOCOL CODE: GIGAVFFOXP

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

Day 1: 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, 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, creatinine less than or equal to 1.5 times the upper limit of normal *and* less than or equal to 1.5 x baseline**.

Days 15 and 29: 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

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: (Note – continued over 2 pages)

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

pembrolizumab 4 mg/kg x _____ kg = _____ mg **(max. 400 mg)**
IV in 50 mL NS over 30 minutes using a 0.2 micron in-line filter on **Day 1**

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* on **Days 1, 15 and 29**. Flush line with 25 mL D5W pre and post dose.

leucovorin 400 mg/m^2 x BSA = _____ mg IV in 250 mL D5W over 2 hours* on **Days 1, 15 and 29**
*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 on **Days 1, 15 and 29**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

DATE:

CHEMOTHERAPY: (Continued)

fluorouracil 400 mg/m² x BSA = _____ mg

☐ Dose Modification: _____mg/m² x BSA = _____mg

IV push on **Days 1, 15 and 29, THEN**

fluorouracil 2400 mg/m² x BSA = _____ mg**

☐ Dose Modification: _____mg/m² 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 on **Days 1, 15 and 29**

** 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	

RETURN APPOINTMENT ORDERS

☐ Return in **six** weeks for Doctor and for Cycle _____
Book chemo on days 1, 15, and 29

☐ Return in _____ weeks for Doctor assessment

☐ Last Cycle. Return in _____ week(s)

CBC and diff, platelets, creatinine, alkaline phosphatase, ALT, total bilirubin, LDH, sodium, potassium, magnesium, calcium, TSH prior to Day 1 and 29 of each cycle

CBC and diff, platelets on Day 15 of 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**

☐ **Book for PICC assessment / insertion per Centre process**

☐ **Book for IVAD insertion per Centre process**

☐ **Weekly nursing assessment**

☐ **Other consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: