

PROTOCOL CODE: GIGAVRAMT

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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: _____					
<input type="checkbox"/> Delay Treatment _____ week(s) <input type="checkbox"/> CBC & Diff, platelets day of treatment May proceed with doses as written if within 24 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L (ramucirumab days: BP less than or equal to 160/100, and urine dipstick negative or +1) Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____					
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. 45 minutes prior to Treatment: dexamethasone 10 mg IV in 50 mL NS over 15 minutes. 30 minutes prior to Treatment: diphenhydramine 25 mg IV in NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible) <input type="checkbox"/> No pre-medication required for PACLitaxel. If PACLitaxel not given or no pre-medication required for PACLitaxel give: diphenhydramine 25 mg IV prior to ramucirumab. <input type="checkbox"/> Other: _____					
Have Hypersensitivity Reaction Tray and Protocol Available					
CHEMOTHERAPY : Use a different filter for each drug. ramucirumab 8 mg/kg x _____ kg = _____ mg on Days 1 and 15 <input type="checkbox"/> Dose Modification: _____ mg/kg x _____ kg = _____ mg IV in 250 to 500 mL NS over 1 hour to 1 hour 30 min (use 0.2 micron in-line filter) (Blood pressure measurement pre and post doses for first 3 cycles and prior to ramucirumab for subsequent cycles) PACLitaxel 80 mg/m² x BSA = _____ mg on Days 1, 8 and 15 <input type="checkbox"/> Dose Modification: _____ mg/m ² x BSA = _____ mg IV in 100 mL to 250 mL (use non-DEHP bag) NS over 1 hour (Use non-DEHP tubing with 0.2 micron in-line filter)					
ADDITIONAL DOSE MODIFICATION IF REQUIRED: Use a different filter for each drug. ramucirumab _____ mg/kg x _____ kg = _____ mg IV in 250 to 500 mL NS over 1 hour to 1 hour 30 min (use 0.2 micron in-line filter) (Blood pressure measurement pre and post doses for first 3 cycles and prior to ramucirumab for subsequent cycles) PACLitaxel _____ mg/m² x BSA = _____ mg IV in 100 mL to 250 mL (use non- DEHP bag) NS over 1 hour (Use non-DEHP tubing with 0.2 micron in-line filter)					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

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DATE:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____. Book chemo weekly x 3 weeks. <input type="checkbox"/> Last Cycle. Return in _____ weeks from last treatment.	
<p>CBC & Diff, Platelets prior to Days 1, 8 and 15</p> <p>Blood Pressure Measurement prior to Days 1 and 15</p> <p>Dipstick Urine or laboratory urinalysis for protein prior to Days 1 and 15. (If results are 2+ or higher, or greater than or equal to 1 g/L laboratory urinalysis for protein, then a 24 hr urine for total protein must be done within 3 days prior to next cycle.)</p> <input type="checkbox"/> Bilirubin <input type="checkbox"/> AST <input type="checkbox"/> ALT <input type="checkbox"/> TSH <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: