

Adult Outpatient Chemotherapy Order Form

Diagnosis / Indications: CRC
 Regimen: Cetuximab
 Cycle #: _____
 Reference: Cunningham D, et al. N Eng J Med 2004;351:337-45; LaPlant KD, et al. GI ASCO 2009:415
 Begin Therapy Day # 1 / /

Patient Height (cm): _____
 Weight (kg): Actual _____ Ideal: _____ Used: _____
 Body Surface Area (m²): Actual: _____ Ideal: _____ Used: _____
 Allergies (reactions): _____

	DRUG (Oral or injectable)	PROTOCOL DOSAGE (Per M ² or Per Kg)	PATIENT'S DOSE	ROUTE	GIVE ON DAYS
1	Cetuximab	400 mg/m ²		IV	Day 1, Week 1
	Fluid / Volume: Minimal volume		Flow Rate or Infusion Time: 120 minutes (see test dose)		
2	Cetuximab	250 mg/m ²		IV	Weekly
	Fluid / Volume: Minimal volume		Flow Rate or Infusion Time: 60 minutes		
3	Cetuximab (TEST DOSE)	100 mg	100 mg	IV over 30 minutes	Day 1, Cycle 1 ONLY
	Monitor patient for hypersensitivity reaction q10min. during test dose and for 30 minutes beyond. If no reaction, pharmacy to mix and dispense remainder of cetuximab prescribed dose to complete infusion over 120 minutes with routine monitoring.				

Follow-up appt.: _____ with labs _____

Specific Administration Instructions/Requirements:

- ANC greater than 1,000 ANC greater than 1,500 Platelets greater than 100,000
- 1. Institute extravasation protocol in the event of a suspected extravasation
- 2. Monitor for hypersensitivity/allergic reaction. If suspected, then follow hypersensitivity/anaphylaxis orders per the Emergency Physician's Order protocol.
- Labs: Magnesium CBC w/diff CMP BMP CEA Other _____

Pre-medications:

- 1. Diphenhydramine 50 mg IV x 1 dose

PRN Medications (please check appropriate meds):

- Lorazepam 1 mg IV PRN nausea or anxiety x 1 dose Prochlorperazine 10 mg IV PRN N/V x 1 dose
- Promethazine 25 mg IV PRN N/V x 1 dose Diphenhydramine 25 mg IV PRN infusion reaction x 1 dose
- Hydrocortisone 100 mg IV PRN infusion reaction x 1 dose Dexamethasone 20 mg IV PRN infusion reaction x 1 dose
- Ranitidine 50 mg IV PRN infusion reaction x 1 dose

Take-home medications (please check appropriate meds):

- Prochlorperazine 10 mg PO q6hr PRN nausea and vomiting # _____ **OR**
- Promethazine 25 mg PO q6hr PRN nausea and vomiting # _____
- Loperamide 2 mg per diarrhea protocol # _____

Special Instructions/Extra Orders: Counsel on dermatologic toxicity management and sun avoidance

Date _____ Time _____ Physician / PA / RPh _____ Provider # _____ Beeper # _____
 Date _____ Time _____ Signature of Oncology Attending / Fellow _____ MD
 Print Name of Attending / Fellow _____ MD # _____

Pharmacy Use Only:
084961-B-1



Patient Name: _____ Patient Identification #: _____

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