Regimen Reference Order – GAST – FOLFOX-6 desensitization

ARIA: GAST - [FOLFOX-6 (MET) (DESENS)]

Planned Course: Every 14 days until disease progression or unacceptable toxicity
Indication for Use: Colorectal Cancer Metastatic / Eligible patients with previous hypersensitivity reactions to oxaliplatin

Alert: Desensitization protocol

oxaliplatin:

- ***This Regimen Reference Order applies only to oxaliplatin doses prepared in a total volume of 500 mL D5W by Pharmacy. For those doses prepared in other volumes for stability, this Regimen Reference Order does not apply as administration rates would need to be adjusted***
- ***oxaliplatin must be the first chemotherapy agent administered when given in combination with another chemotherapy agent***
- ***IV tubing is primed with oxaliplatin (Cytotoxic)***
- ***oxaliplatin is administered slowly following specified rate increases. oxaliplatin infusion takes approximately 4.5 hours to complete***

CVAD: Required (Ambulatory Pump)

Proceed with treatment if:
ANC equal to or greater than 1.5 x 10^9/L AND Platelets equal to or greater than 100 x 10^9/L

- **Contact Physician if parameters not met**

SEQUENCE OF MEDICATION ADMINISTRATION

Pre-treatment Requirements

Drug	Dose	CCMB Administration Guideline
montelukast	10 mg	Orally once daily the day before oxaliplatin **Nursing Alert: Notify physician if patient has not taken montelukast* **(Self-administered at home)**

Treatment Regimen – GAST – FOLFOX-6 desensitization

Establish primary solution 500 mL of: D5W

Drug	Dose	CCMB Administration Guideline
cetirizine	20 mg	Orally **1 hour** prior to oxaliplatin
acetylsalicylic acid (ASA)	650 mg	Orally **1 hour** prior to oxaliplatin

montelukast	10 mg	Orally **1 hour** prior to oxaliplatin
ondansetron	16 mg	Orally 30 minutes pre-chemotherapy
dexamethasone	20 mg	IV in normal saline 50 mL over 15 minutes **1 hour** prior to oxaliplatin **Nursing Alert: oxaliplatin starts **1 hour after completion** of dexamethasone*
famotidine	20 mg	IV in normal saline 50 mL over 15 minutes **45 minutes** prior to oxaliplatin
Wait 45 minutes after completion of IV pre-medication(s) before starting oxaliplatin		
oxaliplatin	100 mg/m^2	IV in D5W 500 mL following the administration rates below: ***Step 1:*** 2 mL/hour for 15 minutes, then ***Step 2:*** 4 mL/hour for 15 minutes, then ***Step 3:*** 6 mL/hour for 15 minutes, then ***Step 4:*** 8 mL/hour for 15 minutes, then ***Step 5:*** 10 mL/hour for 15 minutes, then ***Step 6:*** 15 mL/hour for 15 minutes, then ***Step 7:*** 30 mL/hour for 15 minutes, then **Nursing Alert: Start leucovorin if ordered as part of oxaliplatin-based protocol. There is no interruption in oxaliplatin infusion* ***Step 8:*** 60 mL/hour for 15 minutes, then ***Step 9:*** 80 mL/hour for 15 minutes, then ***Step 10:*** 100 mL/hour for 15 minutes, then ***Step 11:*** 120 mL/hour for 15 minutes, then ***Step 12:*** 140 mL/hour for 15 minutes, then ***Step 13:*** 160 mL/hour for 15 minutes, then ***Step 14:*** 180 mL/hour for 15 minutes, then ***Step 15:*** 200 mL/hour for 15 minutes, then ***Step 16:*** 400 mL/hour for 15 minutes, then ***Step 17:*** 600 mL/hour until infusion is complete **Alert: Pharmacy to ensure final volume in bag = 500 mL for doses stable in that volume* **Alert: oxaliplatin must be the first chemotherapy agent administered when given in combination with another chemotherapy agent* **Nursing Alert: IV tubing is primed with oxaliplatin* **Nursing Alert: If leucovorin is part of the protocol, leucovorin can be infused over the final 2 hours of the oxaliplatin infusion using a Y-site connector*
leucovorin	400 mg/m^2	IV in D5W 500 mL over 2 hours
fluorouracil	400 mg/m^2	IV Push over 5 minutes
fluorouracil	2400 mg/m^2	IV in D5W continuously over 46 hours by ambulatory infusion device
All doses will be automatically rounded that fall within CCMB Approved Dose Bands. See Dose Banding document for more information		

In the event of an infusion-related hypersensitivity reaction, refer to the **'Hypersensitivity Reaction Standing Order'**

REQUIRED MONITORING

All Cycles

- CBC, biochemistry and liver enzymes as per Physician Orders
- Full vital signs (temperature, heart rate, respiratory rate, blood pressure and O_2 saturation) at baseline and as clinically indicated
- No observation period is required after oxaliplatin administration. Patient can be discharged from treatment room if stable whether they had a reaction or not

Recommended Support Medications

Drug	Dose	CCMB Administration Guideline
dexamethasone	8 mg	Orally once daily on Days 2 and 3
prochlorperazine	10 mg	Orally every 6 hours as needed for nausea and vomiting

DISCHARGE INSTRUCTIONS

- Patients should be instructed to contact their cancer team immediately if symptoms of hypersensitivity reactions occur after discharge
- Instruct patient to continue taking anti-emetic(s) at home
- Ensure patient has received a home chemotherapy spill kit and instructions for use
- Reinforce applicable safe handling precautions of medications, blood and body fluids for 48 hours after completion of chemotherapy

ADDITIONAL INFORMATION

- Oncologist must write first prescription of oxaliplatin desensitization protocol
- Once the patient requires oxaliplatin desensitization protocol, all subsequent oxaliplatin doses must be given using the desensitization protocol
- Administration site restrictions may be in place for oxaliplatin desensitization
- oxaliplatin causes cold intolerance and laryngopharyngeal dysesthesia
    - no ice chips or cold drinks
- oxaliplatin may cause progressive, irreversible neuropathy
    - dose modification may be required