



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/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: GIFIRINOX

Page 1 of 3

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 day of treatment May proceed with doses as written if within 72 hours ANC greater than or equal to $1.5 \times 10^9/L$, platelets greater than or equal to $75 \times 10^9/L$ 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 _____. dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO 30 to 60 minutes prior to treatment (omit if below dexamethasone IV premedication ordered) and select ONE of the following:					
<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to treatment on Day 1, then 80 mg PO daily on Day 2 and 3				
<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to treatment				
<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment				
<input type="checkbox"/> Prophylactic atropine 0.3 mg subcutaneously 30 minutes prior to irinotecan <input type="checkbox"/> For prior oxaliplatin hypersensitivity reactions (Grade 1 or 2): 45 minutes prior to oxaliplatin: dexamethasone 20 mg IV in 50 mL NS over 15 minutes 30 minutes prior to oxaliplatin: diphenhydramine 50 mg IV in NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible)					
NO ice chips <input type="checkbox"/> Other: _____					
** Have Hypersensitivity Reaction Tray & Protocol Available **					
TREATMENT: (Note – continued over 2 pages) <input type="checkbox"/> repeat in 2 weeks All lines to be primed with D5W oxaliplatin $85 \text{ mg/m}^2 \times \text{BSA} = \text{_____ mg}$ <input type="checkbox"/> Dose Modification: _____ $\text{mg/m}^2 \times \text{BSA} = \text{_____ mg}$ IV in 250 to 500 mL D5W over 2 hours leucovorin (select one if fluorouracil IV push ordered; optional if fluorouracil IV push omitted) <input type="checkbox"/> leucovorin $400 \text{ mg/m}^2 \times \text{BSA} = \text{_____ mg}$ <input type="checkbox"/> Dose Modification: _____ $\text{mg/m}^2 \times \text{BSA} = \text{_____ mg}$ IV in 250 mL D5W over 1 hour 30 minutes* OR <input type="checkbox"/> leucovorin $20 \text{ mg/m}^2 \times \text{BSA} = \text{_____ mg}$ IV push					
*** CONTINUED ON PAGE 2 ***					
DOCTOR'S SIGNATURE:					SIGNATURE:
					UC:

PROTOCOL CODE: GIFIRINOX

Page 2 of 3

DATE:

TREATMENT: (Continued)

irinotecan 180 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ mg/m² x BSA = _____ mg

IV in 500 mL D5W over 1 hour 30 minutes*

* irinotecan and leucovorin may be infused at the same time by using a Y connector placed immediately before the injection site.

flourouracil

IV push (optional)

☐ fluorouracil 400 mg/m² x BSA = _____ mg

☐ Dose Modification: _____ mg/m² x BSA = _____ mg

IV push THEN

Infusion (required)

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

** 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	

Counsel patient to obtain supply of loperamide and take 4 mg PO at first onset of diarrhea and then 2 mg PO q 2 h until diarrhea free x 12 hours (may take 4 mg PO q 4 h during the night).

atropine 0.3 subcutaneously prn. **May** repeat **every 30 min to a maximum dose of 1.2 mg** for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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PROTOCOL CODE: GIFIRINOX

Page 3 of 3

DATE:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Return in two weeks for Doctor and Cycle _____	
<input type="checkbox"/> Return in four weeks for Doctor and Cycle _____ and _____	
<input type="checkbox"/> Last Cycle. Return in _____ week(s).	
CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle If clinically indicated: <input type="checkbox"/> ECG <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9 <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> albumin <input type="checkbox"/> GGT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> random glucose <input type="checkbox"/> HbA1c <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> Other tests: <input type="checkbox"/> Book for PICC assessment / insertion per Centre process <input type="checkbox"/> Book for IVAD insertion per Centre process <input type="checkbox"/> Weekly nursing assessment for (specify concern): _____ <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: