**PROTOCOL CODE: GIFIRINOX**

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht_________cm</th>
<th>Wt_________kg</th>
<th>BSA_________m²</th>
</tr>
</thead>
</table>

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

**DATE:**

To be given: _______________________

Cycle #: _______________________

Date of Previous Cycle:

- ☐ Delay treatment _____ week(s)
- ☐ CBC & Diff, Platelets 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:  ☐ Hematology  ☐ Other Toxicity ____________________________

Proceed with treatment based on blood work from ________________

**PREMEDICATIONS:** Patient to take own supply. RN/Pharmacist to confirm ____________________________.

- netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to treatment
- dexamethasone 8 mg or 12 mg (circle one) PO 30 to 60 minutes prior to treatment
- prophylactic atropine 0.3 mg s.c.
- NO ice chips
- Other: _____________________________

**CHEMOTHERAPY:** *(Note – continued over 2 pages)*

All lines to be primed with D5W

- oxaliplatin $85 \text{ mg/m}^2 \times \text{BSA} = \underline{\text{mg}}$
  - ☐ Dose Modification: $\underline{\text{mg/m}^2 \times \text{BSA}} = \underline{\text{mg}}$
  - IV in 250 to 500 mL D5W over 2 hours immediately followed by

- leucovorin $400 \text{ mg/m}^2 \times \text{BSA} = \underline{\text{mg}}$
  - ☐ Dose Modification: $\underline{\text{mg/m}^2 \times \text{BSA}} = \underline{\text{mg}}$
  - IV in 250 mL D5W over 1 hour 30 minutes*

- irinotecan $180 \text{ mg/m}^2 \times \text{BSA} = \underline{\text{mg}}$
  - ☐ Dose Modification: $\underline{\text{mg/m}^2 \times \text{BSA}} = \underline{\text{mg}}$
  - 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. Immediately followed by

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

<table>
<thead>
<tr>
<th>DOCTOR’S SIGNATURE:</th>
<th>SIGNATURE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UC:</td>
</tr>
</tbody>
</table>
DOCTOR’S ORDERS

DATE:

CHEMOTHERAPY: (Continued)

**fluorouracil 400 mg/m\(^2\) x BSA = _________ mg

☐ Dose Modification: _________ mg/m\(^2\) x BSA = _________ mg

IV push THEN

**fluorouracil 2400 mg/m\(^2\) x BSA = _________ mg**

☐ Dose Modification: _________ mg/m\(^2\) 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):**

<table>
<thead>
<tr>
<th>Dose Banding Range</th>
<th>Dose Band INFUSOR (mg)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3000 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
<tr>
<td>3000 to 3400 mg</td>
<td>3200 mg</td>
<td></td>
</tr>
<tr>
<td>3401 to 3800 mg</td>
<td>3600 mg</td>
<td></td>
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<tr>
<td>3801 to 4200 mg</td>
<td>4000 mg</td>
<td></td>
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<tr>
<td>4201 to 4600 mg</td>
<td>4400 mg</td>
<td></td>
</tr>
<tr>
<td>4601 to 5000 mg</td>
<td>4800 mg</td>
<td></td>
</tr>
<tr>
<td>5001 to 5500 mg</td>
<td>5250 mg</td>
<td></td>
</tr>
<tr>
<td>Greater than 5500 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
</tbody>
</table>

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 to 0.6 mg** SC prn repeat up to 1.2 mg for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.

RETURN APPOINTMENT ORDERS

☐ Return in **two** weeks for Doctor and Cycle _____

☐ Return in **four** weeks for Doctor and Cycle _____ and _____

☐ Last Cycle. Return in ______ week(s).

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca prior to each cycle

☐ INR weekly  ☐ INR prior to each cycle

☐ ECG  ☐ CEA  ☐ CA 19-9

☐ Other tests:

☐ Book for PICC assessment / insertion per Centre process

☐ Book for IVAD insertion per Centre process

☐ Weekly Nursing Assessment for (specify concern): ______________________

☐ Consults:

☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE:  

SIGNATURE:  

UC: