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 and according to acceptable standards of care.

**PROTOCOL CODE: GIFOLFIRI**

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<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(s) #: 

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 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/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 ___________________________.

- ondansetron 8 mg PO prior to treatment
- dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment
- Prophylactic atropine 0.3 mg SC
- Other:

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

- Repeat in two weeks  □ Repeat in two and in four weeks

  - irinotecan 180 mg/m² x BSA = ________ mg
  - Dose Modification: __________mg/m² x BSA = ________mg
  - IV in 500 mL D5W over 1 hour 30 minutes*

  - leucovorin 400 mg/m² x BSA = ________ mg
  - IV in 250 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.

OR

- leucovorin 20 mg/m² x BSA = ________ mg
  - IV push

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

**DOCTOR’S SIGNATURE:** ____________________________

**SIGNATURE:** ____________________________

**UC:** BC Cancer Provincial Preprinted Order GIFOLFIRI

Created: April 4, 2005 Revised: 1 May 2018
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PROTOCOL CODE: GIFOLFIRI

DATE:

CHEMOTHERAPY: (Continued)

fluorouracil 400 mg/m² x BSA = ________ mg
☐ Dose Modification: __________mg/m² x BSA = __________mg
IV push THEN
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):

<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>
</tr>
<tr>
<td>3801 to 4200 mg</td>
<td>4000 mg</td>
<td></td>
</tr>
<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 Cycles _____ & _______. Book chemo x 2 cycles
☐ Return in six weeks for Doctor and Cycle _____, _____ & _______. Book chemo x 3 cycles.
☐ Last Cycle. Return in ________ week(s)

CBC & Diff, Platelets, prior to each cycle
Billirubin, ALT, Alk Phos, Creatinine prior to each doctor’s visit
☐ INR weekly  ☐ INR prior to each cycle
☐ 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: