

PROTOCOL CODE: GIFOLFOX

Page 1 of 2

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(s) #: _____	
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 $1.2 \times 10^9/L$, 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 _____. ondansetron 8 mg PO prior to treatment dexamethasone <input type="checkbox"/> 8 mg or <input type="checkbox"/> 12 mg (select one) PO prior to treatment (omit if below dexamethasone IV premedication ordered) <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 two weeks <input type="checkbox"/> Repeat in two and in four weeks All lines to be primed with D5W oxaliplatin $85 \text{ mg/m}^2 \times \text{BSA}$ = _____ mg <input type="checkbox"/> Dose Modification: _____ mg/m ² \times BSA = _____ 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 $400 \text{ mg/m}^2 \times \text{BSA}$ = _____ mg IV in 250 mL D5W over 2 hours* *oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site OR <input type="checkbox"/> leucovorin $20 \text{ mg/m}^2 \times \text{BSA}$ = _____ mg IV push			
*** CONTINUED ON PAGE 2 ***			
DOCTOR'S SIGNATURE: _____			SIGNATURE: _____ UC: _____

PROTOCOL CODE: GIFOLFOX

Page 2 of 2

DATE:

TREATMENT: (Continued)

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	

RETURN APPOINTMENT ORDERS

- ☐ Return in **two** weeks for Doctor and Cycle _____
☐ Return in **four** weeks for Doctor and Cycles _____ & _____. Book **treatment** x 2 cycles
☐ Return in **six** weeks for Doctor and Cycles _____, _____ & _____. Book **treatment** x 3 cycles
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, creatinine, total bilirubin, ALT prior to each cycle

If clinically indicated:

- ☐ CEA ☐ CA 19-9 ☐ ECG
☐ alkaline phosphatase ☐ albumin ☐ GGT ☐ sodium ☐ potassium
☐ INR weekly ☐ INR prior to each cycle
☐ 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: