PROTOCOL CODE: GIIRINALT

*For other indications or for more than 6 cycles, a BCCA “Compassionate Access Program” request form must be completed and approved prior to treatment.*

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>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/Week #:

Date of Previous Cycle:

- Delay treatment _____ week(s)
- CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 24 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 ________________.

- Ondansetron 8 mg PO prior to treatment
- Dexamethasone 8 mg or 12 mg (circle one) prior to treatment
- Prophylactic atropine 0.3 mg SC
- Other: ________________

**CHEMOTHERAPY:**

- Irinotecan $125 \text{mg/m}^2 \times \text{BSA} = _____ \text{mg}$
- Dose Modification: ___________mg/m² × BSA = _______mg
  - IV in 500 mL D5W over 1 hour 30 minutes

- Repeat doses as written weekly x 4

**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 ______ weeks for Doctor and Cycle _____. Book chemo weekly x 4
- Last Cycle. Return in ________ weeks.

**CBC & Diff, Platelets** prior to each treatment

If clinically indicated:

- CEA
- CA 19-9
- Bilirubin
- ALT
- Alk Phos

- Imaging Study:
- Other tests:
- Consults:
- See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:** ___________  
**SIGNATURE:** ___________  
**UC:** ___________