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: GIPAJFIROX**

<table>
<thead>
<tr>
<th>DOCTOR'S ORDERS</th>
<th>Ht_______cm Wt_______kg BSA_______m²</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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
- **aprepitant 125 mg** PO
- □ prophylactic atropine 0.3 mg s.c.
- NO ice chips
- □ Other:

CHEMOTHERAPY: (Note – continued over 2 pages) □ repeat in 2 weeks

All lines to be primed with D5W

- **oxaliplatin 85 mg/m² x BSA = _________ mg**
  - □ Dose Modification: ___________mg/m² x BSA = _________mg
  - IV in 250 to 500 mL D5W over 2 hours immediately followed by

- **leucovorin 400 mg/m² x BSA = _________ mg**
  - □ Dose Modification: ___________mg/m² x BSA = _________mg
  - IV in 250 mL D5W over 2 hours with the addition after 30 minutes of

- **irinotecan 150 mg/m² x BSA = _________ mg**
  - □ Dose Modification: ___________mg/m² x BSA = _________mg
  - IV in 500 mL D5W over 1 hour 30 minutes given through 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>
<th>UC:</th>
</tr>
</thead>
</table>
**DOCTOR’S ORDERS**

**DATE:**

**CHEMOTHERAPY:** (Continued)

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>
</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 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 ☐ CA 19-9

☐ Other tests:

☐ If appropriate : G-CSF

☐ 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:**