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

**DATE:**

<table>
<thead>
<tr>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
</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** $1.5 \times 10^9/L$, **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) 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 1 hour 30 minutes*

- **Irinotecan 150 mg/m² x BSA = _________ mg**
  - □ Dose Modification: _________mg/m² x BSA = _________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***

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**

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BC Cancer Provincial Preprinted Order GIPAJFIROX
Created: 1 Aug 2019    Revised: 1 Nov 2019
DOCTOR’S ORDERS

DATE:

CHEMOTHERAPY: (Continued)

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 Cycle _____ and _____
☐ Last Cycle. Return in _______ week(s).

CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Sodium, Potassium, Mg, Ca, random glucose 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:

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