PROTOCOL CODE: GIPAJFIROX

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 #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.5 x 10^9/L, platelets greater than or equal to 100 x 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 _____.

dexamethasone ☐ **8 mg** or ☐ **12 mg** (select one) PO 30 to 60 minutes prior to treatment (omit if below dexamethasone IV premedication ordered)

and **select** ONE of the following:

☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to treatment on Day 1, then **80 mg** PO daily on Day 2 and 3 **ondansetron 8 mg** PO 30 to 60 minutes prior to treatment
☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to treatment

☐ Prophylactic **atropine 0.3 mg** subcutaneously 30 minutes prior to irinotecan

☐ 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

☐ **Other:**

**** Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT: (Note – continued over 2 pages) ☐ **repeat in 2 weeks**

All lines to be primed with D5W

oxaliplatin 85 mg/m^2 x BSA = _____ mg

☐ Dose Modification: _____mg/m^2 x BSA = _____mg

IV in 250 to 500 mL D5W over 2 hours immediately followed by

*** CONTINUED ON PAGE 2 ***

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:

TREATMENT: (Continued)

leucovorin 400 mg/m² x BSA = _____ mg
☐ Dose Modification: _____mg/m² x BSA = _____mg
IV in 250 mL D5W over 1 hour 30 minutes*

OR

☐ **leucovorin 20 mg/m²** x BSA = _____ mg
IV push

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.

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	

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 subcutaneously prn. May repeat every 30 min to a **maximum dose of 1.2 mg** for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis or flushing.

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:	
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, creatinine, total bilirubin, ALT prior to each cycle If clinically indicated: ☐ **ECG** ☐ **CA 19-9** ☐ **CEA** ☐ **alkaline phosphatase** ☐ **albumin** ☐ **GGT** ☐ **sodium** ☐ **potassium** ☐ **random glucose** ☐ **HbA1c** ☐ **INR** weekly ☐ **INR** prior to each cycle ☐ **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:**