CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet

FOLFIRINOX (Modified) Regimen:

OXALIplatin 85 - leucovorin 400 - irinotecan 150 - fluorouracil 2400 (Part I)

ARIA Protocol Name: FOLFIRNOX (Modified)

Adult Chemotherapy - Medical Oncology

Advanced Pancreatic Cancer Therapy

CC3590 0170 06 2021

Name:

HCN:

Date of Birth:

Allergies: ☐ **No Known**

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle_____ of _____ **Cycle Duration: 14 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.5 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/L, otherwise notify Medical Oncologist.
- LFT's and Bilirubin assessed.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

☐ **fosaprepitant 150 mg IV** in 150 mL normal saline over 30 minutes on day 1

☐ **ondansetron 8 mg PO** on day 1

☐ **dexamethasone 8 mg PO** on day 1

☐ Other Medications: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT.

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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Cancer Care Program

Doctor's Order Sheet

FOLFIRINOX (Modified) Regimen:

OXALIplatin 85 - leucovorin 400 - irinotecan 150 - fluorouracil 2400 (Part II)

ARIA Protocol Name: FOLFIRNOX (Modified)

Adult Chemotherapy - Medical Oncology

Advanced Pancreatic Cancer Therapy

Name :

HCN :

Date of Birth:

CC3590 0170 06 2021

Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **OXALIplatin 85 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **OXALIplatin 85 mg/m²** X BSA - _____% = _____ **mg**

IV in 500 mL D5W over 120 minutes on day 1

☐ **leucovorin calcium 400 mg/m²** X BSA= _____**mg**

IV in 250 mL D5W over 90 minutes on day 1

☐ **irinotecan 150 mg/m²** X BSA = _____ **mg**

☐ Dose modification: **irinotecan 150 mg/m²** X BSA - _____% = _____**mg**

IV in 500 mL D5W over 90 minutes on day 1

☐ **fluorouracil 2400 mg/m²** X BSA=_____**mg**

☐ Dose modification: **fluorouracil 2400 mg/m²** X BSA - _____% = _____**mg**

IV in 230 mL D5W over 46 hours

HYDRATION/SUPPORTIVE CARE MEDICATIONS (FOR HOSPITAL PHARMACY):

atropine 0.4 mg intravenous prn for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis, or flushing.

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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