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: GICOXB

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(s) #:**

Date of Previous Cycle:

☐ Delay treatment ______ week(s)
☐ **CBC & Diff, Platelets** day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to 1.2 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than or equal to 50 mL/minute, BP less than or equal to 160/100.** For those patients on warfarin, **hold bevacizumab if INR greater than 3.0**

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
☐ **Other:**

CHEMOTHERAPY: ☐ **Repeat in three weeks**
oxaliplatin line to be primed with D5W; bevacizumab line to be primed with NS

oxaliplatin 130 mg/m^2 x BSA = ________ mg
☐ Dose Modification: ___________mg/m^2 x BSA = _________mg
IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post oxaliplatin
☐ RN to administer 250 to 1000 mL D5W concurrently with oxaliplatin infusion, titrated to reduce phlebitis discomfort for patient

bevacizumab 7.5 mg/kg x _________ kg = _________ mg
IV in 100 mL NS over 15 minutes. Flush line with 25 mL NS pre and post bevacizumab.
(Blood pressure measurement pre and post dose for first 3 cycles and prior to bevacizumab for subsequent cycles)

Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190

Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date
bevacizumab		

capecitabine 1000 mg/m^2 or ______ x BSA x (_______%) = _______ mg PO BID x 14 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:

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DATE:

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _______

☐ Return in **six** weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles

☐ Last Cycle. Return in _________ week(s)

CBC & Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Albumin, Sodium, Potassium, Magnesium, Calcium and Blood Pressure Measurement prior to each cycle

Dipstick Urine or laboratory urinalysis for protein at the beginning of each **even** numbered cycle. (If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then a **24 hr urine for total protein** must be done within 3 days prior to next cycle.)

☐ **INR** weekly ☐ **INR** prior to each cycle

☐ **CEA** ☐ **CA 19-9**

☐ **ECG**

☐ **Other tests:**

☐ **Weekly Nursing Assessment for (specify concern):** ______________________

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: