PROTOCOL CODE: GOCABRBEV

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**, **platelets** 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, BP less than or equal to 150/100 mmHg.** For 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 _____.

dexamethasone ☐ **8 mg or** ☐ **12 mg** (select one) PO 30 to 60 minutes prior to **CARBOplatin**

AND select **ONE** of the following:	☐	**ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**aprepitant 125 mg** PO 30 to 60 minutes prior to CARBOplatin, and **ondansetron 8 mg** PO 30 to 60 minutes prior to CARBOplatin
	☐	**netupitant-palonosetron 300 mg-0.5 mg** PO 30 to 60 minutes prior to CARBOplatin

If additional antiemetic required:
☐ **OLANZapine** ☐ **2.5 mg** or ☐ **5 mg** or ☐ **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin
☐ **Other:**

**** Have Hypersensitivity Reaction Medications and Protocol Available****

CHEMOTHERAPY:

PACLitaxel NAB (ABRAXANE) 260 mg/m^2 x BSA = _____mg
☐ Dose Modification: _____% = _____mg
IV over 30 minutes (in empty sterile PVC, non-PVC or non-DEHP bag and tubing; use tubing with **15** micron filter)

CARBOplatin AUC 6 or 5 (circle one) x (GFR + 25) = _____ mg
☐ Dose Modification: _____% = _____ mg
IV in 100 to 250 mL NS over 30 minutes.

Blood pressure measurement pre-bevacizumab dose.

bevacizumab 7.5 mg/kg x _____ kg = _____ mg
IV in 100 mL NS over 15 minutes (first infusion over 1 hour).
OR
bevacizumab 15 mg/kg x _____ kg = _____ mg
IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour).

Blood pressure measurement post-bevacizumab infusion for first 3 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		

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

DOCTOR'S ORDERS

DATE:

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____.

☐ Last Treatment. Return in _____ week(s).

CBC & Diff, platelets, creatinine, laboratory urinalysis *or* **urine dipstick for protein** prior to next cycle.

☐ **CBC & Diff, platelets** on Day 14.

☐ **24 h urine for total protein** within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein

☐ **INR** weekly ☐ **INR** prior to next cycle

Prior to next cycle, if clinically indicated:

☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **ALT** ☐ **LDH**
☐ **Tot Prot** ☐ **Albumin**
☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9** ☐ **CEA** ☐ **SCC**

☐ **Refer to Hereditary Cancer Program (see accompanying referral form)**
☐ **Other tests:**
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: