DOCTOR'S ORDERS

Ht_____**cm** **Wt**_____**kg** **BSA**_____**m²**

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 1.0 x 10^9/L, Platelets greater than or equal to 100 x 10^9/L,** BP less than or equal to 150/100, and urine dipstick for protein negative or 1+.

Dose modification for: ☐ **Hematology** ☐ **Other Toxicity** _____

Proceed with treatment based on blood work from _____

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

45 minutes prior to PACLitaxel:

dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel:

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)

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 Tray and Protocol Available****

CHEMOTHERAPY: (Note – continued over 2 pages)

☐ **CYCLE # 1**

PACLitaxel ☐ **175 mg/m²** OR ☐ _____ **mg/m²** (select one) x BSA =_____ mg

☐ Dose Modification: _____% = _____mg/m² x BSA = _____mg

IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter)

CARBOplatin AUC ☐ **6 or** ☐ **5 (select one) x (GFR + 25)** = _____ mg

☐ Dose Modification: _____% = _____ mg

IV in 100 to 250mL NS over 30 minutes.

ORDERS CONTINUE ON PAGE 2

DOCTOR'S SIGNATURE: **SIGNATURE:**

UC:

DATE:

OR ☐ **CYCLE # ____ (cycle 2-6)**

PACLitaxel ☐ **175 mg/m²** OR ☐ _____ **mg/m²** (select one) x BSA =_____ mg
☐ Dose Modification: _____% = _____mg/m² x BSA = _____mg
IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use non-DEHP tubing with 0.2 micron in-line filter)

CARBOplatin AUC ☐ **6 or** ☐ **5 (select 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).
(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		

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.

If this is Cycle 1: **CBC & Diff, Platelets** on Day 14.
In subsequent cycles, if indicated: **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**

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

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: