



Provincial Health Services Authority

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](http://www.bccancer.bc.ca) and according to acceptable standards of care

**PROTOCOL CODE: GICOXB**

<b>DOCTOR'S ORDERS</b>		Ht _____ cm    Wt _____ kg    BSA _____ m <sup>2</sup>						
<b>REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy &amp; Alert Form</b>								
<b>DATE:</b>	<b>To be given:</b>	<b>Cycle(s) #:</b>						
Date of Previous Cycle: _____								
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> <b>CBC &amp; Diff, Platelets</b> day of treatment								
May proceed with doses as written if within 96 hours <b>ANC greater than or equal to <math>1.2 \times 10^9/L</math>, Platelets greater than or equal to <math>75 \times 10^9/L</math>, Creatinine Clearance greater than or equal to 50 mL/minute, BP less than or equal to 160/100.</b> For those patients on warfarin, <b>hold bevacizumab if INR greater than 3.0</b>								
Dose modification for: <input type="checkbox"/> <b>Hematology</b> <input type="checkbox"/> <b>Other Toxicity</b> _____								
Proceed with treatment based on blood work from _____								
<b>PREMEDICATIONS:</b> Patient to take own supply. RN/Pharmacist to confirm _____. ondansetron 8 mg PO prior to treatment dexamethasone 8 mg or 12 mg ( <i>circle one</i> ) PO prior to treatment <b>NO ice chips</b> <input type="checkbox"/> Other: _____								
<b>CHEMOTHERAPY:</b> <input type="checkbox"/> Repeat in three weeks oxaliplatin line to be primed with D5W; bevacizumab line to be primed with NS  oxaliplatin $130 \text{ mg/m}^2 \times \text{BSA} =$ _____ mg <input type="checkbox"/> Dose Modification: _____ $\text{mg/m}^2 \times \text{BSA} =$ _____ mg IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post oxaliplatin  To reduce incidence of vascular pain: <input type="checkbox"/> 250 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 125 mL/h <input type="checkbox"/> 500 mL total volume of D5W to be administered concurrently with oxaliplatin at a maximum rate of 250 mL/h  bevacizumab $7.5 \text{ mg/kg} \times$ _____ 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								
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Drug</th> <th style="width: 40%;">Brand (Pharmacist to complete. Please print.)</th> <th style="width: 40%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">bevacizumab</td> <td> </td> <td> </td> </tr> </tbody> </table>			Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date	bevacizumab		
Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date						
bevacizumab								
capecitabine $1000 \text{ mg/m}^2$ or _____ $\times \text{BSA} \times$ ( _____ %) = _____ mg PO BID x 14 days (refer to <a href="#">Capecitabine Suggested Tablet Combination Table</a> for dose rounding)								
<b>DOCTOR'S SIGNATURE:</b>		<b>SIGNATURE:</b>						
		<b>UC:</b>						



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<b>DATE:</b>	
<b>RETURN APPOINTMENT ORDERS</b>	
<input type="checkbox"/> Return in <b>three</b> weeks for Doctor and Cycle _____  <input type="checkbox"/> Return in <b>six</b> weeks for Doctor and Cycle _____ & _____. Book chemo x 2 cycles  <input type="checkbox"/> Last Cycle. Return in _____ week(s)	
<p><b>CBC &amp; Diff, Platelets, Creatinine, Bilirubin, ALT, Alk Phos, Albumin, Sodium, Potassium, Magnesium, Calcium and Blood Pressure Measurement</b> prior to each cycle</p> <p><b>Dipstick Urine or laboratory urinalysis for protein</b> at the beginning of each <b>even</b> numbered cycle. (If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein then a <b>24 hr urine for total protein</b> must be done within 3 days prior to next cycle.)</p> <input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle  <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9  <input type="checkbox"/> ECG  <input type="checkbox"/> Other tests:  <input type="checkbox"/> Weekly Nursing Assessment for (specify concern): _____  <input type="checkbox"/> Consults:  <input type="checkbox"/> See general orders sheet for additional requests.	
<b>DOCTOR'S SIGNATURE:</b>	<b>SIGNATURE:</b>  <b>UC:</b>