PROTOCOL CODE: GIAVCAPB

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 1.5 x 10^9/L, Platelets greater than or equal to 75 x 10^9/L, Creatinine Clearance greater than 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: Not usually required for capecitabine or bevacizumab.

If ordered, patient to take own supply. RN/Pharmacist to confirm _____.

CHEMOTHERAPY:

☐ **Repeat in three weeks**

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 ☐ _____ (select one) x BSA x (_____%) = _____ mg PO BID x 14 days
(refer to Capecitabine Suggested Tablet Combination Table for dose rounding)

RETURN APPOINTMENT ORDERS

☐ Return in **three** weeks for Doctor and Cycle _____
☐ Return in **six** weeks for Doctor and Cycles _____ & _____.Book chemo x 2 cycles.
☐ Last Cycle. Return in _____ week(s)

CBC & Diff, Platelets, Creatinine, Blood Pressure Measurement prior to each cycle

☐ **Dipstick Urine or** ☐ **laboratory urinalysis** (select one) **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.)

☐ **Bilirubin** ☐ **ALT** ☐ **Alk Phos** ☐ **GGT** ☐ **Albumin** ☐ **Total Protein**
☐ **BUN** ☐ **Potassium** ☐ **Sodium** ☐ **CEA** ☐ **CA 19-9**
☐ **INR** weekly ☐ **INR** prior to each cycle
☐ **Other tests:**
☐ **Weekly Nursing Assessment for (specify concern):** _____
☐ **Consults:**
☐ **See general orders sheet for additional requests.**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: