# 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** 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 _____.

**TREATMENT:**

☐ **Repeat in three weeks**

**bevacizumab 7.5 mg/kg** x _____ kg = _____ mg

IV in 100 mL NS over 15 minutes.

(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, creatinine, total bilirubin, ALT** 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:
☐ **24 hr urine for total protein** must be done within 3 days prior to next cycle.)

If clinically indicated:
☐ **CEA** ☐ **CA 19-9** ☐ ECG
☐ **alkaline phosphatase** ☐ **GGT** ☐ **albumin**
☐ **potassium** ☐ **sodium**
☐ **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:**