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: GIAVCAPB**

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**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 10⁹/L, Platelets greater than or equal to 75 x 10⁹/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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand (Pharmacist to complete. Please print.)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>bevacizumab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

capecitabine [ ] 1000 mg/m² or [ ] _____ (select one) x BSA x (_______%) = _______ mg PO bid with food x 14 days

(Round to nearest 150 mg)

### 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:**

BC Cancer Provincial Preprinted Order GIAVCAPB

Created: 1 Nov 2018  Revised: 9 Nov 2020