PROTOCOL CODE: GIAVCAPB

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(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 via infusion pump. 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.)

capecitabine 1000 mg/m² or _________ 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 _________& _________.

Last Cycle. Return in _________ week(s)

CBC & Diff, Platelets, Creatinine, Blood Pressure Measurement 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 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: