**PROTOCOL CODE: GIAVCAPB**

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht</th>
<th>cm</th>
<th>Wt</th>
<th>kg</th>
<th>BSA</th>
<th>m²</th>
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**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>
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<tbody>
<tr>
<td>bevacizumab</td>
<td></td>
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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 _____ & _____. 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 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:**