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 and according to acceptable standards of care.

PROTOCOL CODE: GICOXB

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 1.2 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than or equal to 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: Patient to take own supply. RN/Pharmacist to confirm ________________________________.

ondansetron 8 mg PO prior to treatment

dexamethasone 8 mg or 12 mg (circle one) PO prior to treatment

☐ Other:

CHEMOTHERAPY: ☐ Repeat in three weeks

oxaliplatin line to be primed with D5W; bevacizumab line to be primed with NS

oxaliplatin 130 mg/m² x BSA = _______ mg

☐ Dose Modification: _________mg/m² x BSA = _________mg

IV in 250 to 500 mL D5W over 2 hours. Flush line with D5W pre and post oxaliplatin

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>
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</table>

capcitabine 1000 mg/m² or ______ x BSA x ( _______ %) = _______ mg PO bid with food x 14 days

(Round to nearest 150 mg)

DOCTOR’S SIGNATURE:   SIGNATURE:

UC:
**DATE:**

<table>
<thead>
<tr>
<th><strong>RETURN APPOINTMENT ORDERS</strong></th>
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</thead>
<tbody>
<tr>
<td>☐ Return in <strong>three</strong> weeks for Doctor and Cycle ______</td>
<td></td>
</tr>
<tr>
<td>☐ Return in <strong>six</strong> weeks for Doctor and Cycle _____ &amp; ______. Book chemo x 2 cycles</td>
<td></td>
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<tr>
<td>☐ Last Cycle. Return in ______ week(s)</td>
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</tr>
</tbody>
</table>

**CBC & Diff, Platelets, Creatinine, Bili, ALT, Alk Phos, Albumin, Sodium, Potassium, Mg, Ca and 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.)

☐ INR weekly  ☐ INR prior to each cycle

☐ CEA  ☐ CA 19-9

☐ ECG

☐ Other tests:

☐ Weekly Nursing Assessment for (specify concern): ___________________________

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR'S SIGNATURE:**

**SIGNATURE:**

**UC:**