**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 72 hours ANC greater than or equal to 1.2 x $10^9$/L, Platelets greater than or equal to 75 x $10^9$/L, 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
- NO ice chips

**CHEMOTHERAPY:** (Note – continued over 2 pages)

- Repeat in two weeks
- Repeat in two and in four weeks
oxaliplatin line to be primed with D5W; bevacizumab line to be primed with NS

oxaliplatin 85 mg/m² x BSA = _________ mg
- Dose Modification: _________mg/m² x BSA = _________mg
  IV in 250 to 500 mL D5W over 2 hours*

leucovorin 400 mg/m² x BSA = _______ mg
  IV in 250 mL D5W over 2 hours*
  * oxaliplatin and leucovorin may be infused over same two hour period by using a Y-site connector placed immediately before the injection site.

OR

leucovorin 20 mg/m² x BSA = _______ mg
  IV push

fluorouracil 400 mg/m² x BSA = _________ mg
- Dose Modification: _________mg/m² x BSA = _________mg
  IV push

bevacizumab 5 mg/kg x _______ kg = _________ mg
  IV in 100 mL NS over 10 minutes. Flush line with 25 mL NS pre and post dose.
  (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>

*** SEE PAGE 2 FOR FLUOROURACIL INFUSIONAL CHEMOTHERAPY ***

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**
DATE:

CHEMOTHERAPY: (Continued)
fluorouracil 2400 mg/m² x BSA = _______ mg**
☐ Dose Modification: _________mg/m² x BSA = __________mg**
IV over 46 hours in D5W to a total volume of 230 mL by continuous infusion at 5 mL/h via Baxter LV5 INFUSOR
** For 3000 to 5500 mg dose, select INFUSOR per dose range below (doses outside dose banding range are prepared as ordered):

<table>
<thead>
<tr>
<th>Dose Banding Range</th>
<th>Dose Band INFUSOR (mg)</th>
<th>Pharmacist Initial and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3000 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
<tr>
<td>3000 to 3400 mg</td>
<td>3200 mg</td>
<td></td>
</tr>
<tr>
<td>3401 to 3800 mg</td>
<td>3600 mg</td>
<td></td>
</tr>
<tr>
<td>3801 to 4200 mg</td>
<td>4000 mg</td>
<td></td>
</tr>
<tr>
<td>4201 to 4600 mg</td>
<td>4400 mg</td>
<td></td>
</tr>
<tr>
<td>4601 to 5000 mg</td>
<td>4800 mg</td>
<td></td>
</tr>
<tr>
<td>5001 to 5500 mg</td>
<td>5250 mg</td>
<td></td>
</tr>
<tr>
<td>Greater than 5500 mg</td>
<td>Pharmacy to mix specific dose</td>
<td></td>
</tr>
</tbody>
</table>

RETURN APPOINTMENT ORDERS

☐ Return in two weeks for Doctor and Cycle ______
☐ Return in four weeks for Doctor and Cycles _____ & ______. Book chemo x 2 cycles.
☐ Return in six weeks for Doctor and Cycles ____, ____ & _____. Book chemo x 3 cycles.
☐ Last Cycle. Return in ______ week(s).

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
☐ ECG ☐ CEA ☐ CA 19-9
☐ Other tests:
☐ Book for PICC assessment / insertion per Centre process
☐ Book for IVAD insertion per Centre process
☐ Weekly Nursing Assessment for (specify concern): ______________________
☐ Consults:
☐ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: ____________________________

SIGNATURE: ____________________________

UC: ____________________________