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 #:

Date of Previous Cycle:

Delay treatment ______ week(s) and repeat CBC & Diff, Platelets on day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to 1 x 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L, BP less than or equal to 150/100, and urine dipstick for protein negative or 1+.

Dose modification for:

☐ Hematology    ☐ Other Toxicity

Proceed with treatment based on blood work from

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm ___________________________.

45 minutes prior to PACLitaxel:

dexamethasone 20 mg IV in 50 mL NS over 15 minutes

30 minutes prior to PACLitaxel:

diphenhydramINE 50 mg IV and ranitidine 50 mg IV in 50 mL NS over 20 minutes

ondansetron 8 mg PO 30 minutes prior to CARBOplatin

☐ Other:

**Have Hypersensitivity Reaction Tray and Protocol Available**

CHEMOTHERAPY:

PACLitaxel 175 mg/m² or 155 mg/m² or 135 mg/m² (circle one) x BSA = __________ mg

☐ Dose Modification: ______% = ______ mg/m² x BSA = ______ mg

IV in 250 to 500 mL (non-DEHP bag) NS over 3 hours. (Use non-DEHP tubing with 0.22 micron or smaller in-line filter)

CARBOplatin AUC 6 or 5 (circle one) x (GFR + 25) x = __________ mg

☐ Dose Modification: ______% = ______ mg

IV in 250 mL NS over 30 minutes.

Flush line with 10 mL NS pre-bevacizumab. Blood pressure measurement pre-bevacizumab dose.

bevacizumab 15 mg/kg or ______ mg/kg x __________ kg = __________ mg

IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour). Flush line with 25 mL NS post-bevacizumab.

(Blood pressure measurement post-bevacizumab infusion for first 3 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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DOCTOR’S SIGNATURE:    SIGNATURE:
### DATE:

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<tr>
<th>RETURN APPOINTMENT ORDERS</th>
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Return in ☐ **three** weeks, or ☐ **four** weeks for Doctor and Cycle ________  
☐ Last Treatment. Return in _______ week(s).

*If this is Cycle 1 or if a dose change has been made:* **CBC & Diff, Platelets** on Day 14 (and Day 21 if RTC is in four weeks).

**CBC & Diff, Platelets, Creatinine, Laboratory urinalysis** or **Urine dipstick for protein** prior to next cycle *(within 96 hours OK).*

**CBC & Diff, Platelets** on ☐ Day 14 ☐ Day 21

☐ **24 hr urine for total protein** within 3 days prior to next bevacizumab dose if 2+ or 3+ dipstick or greater than or equal to 1 g/L laboratory urinalysis for protein

☐ **INR** weekly ☐ **INR** prior to next cycle

Prior to next cycle, if clinically indicated: ☐ **Bilirubin** ☐ **Alk Phos** ☐ **GGT** ☐ **ALT**  
☐ **LDH** ☐ **Tot Prot** ☐ **Albumin** ☐ **CA 15-3** ☐ **CA 125** ☐ **CA 19-9** ☐ **SCC** ☐ **CEA**

☐ **Other tests:**

**NB** – Repeat any positive imaging after every 2 cycles.

☐ **Consults:**

☐ **See general orders sheet for additional requests.**

#### DOCTOR’S SIGNATURE:  

| SIGNATURE: |

| UC: |