**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 BP less than or equal to 150/100, and within 96 hours of **Day 1:** urine dipstick for protein negative or 1+, ANC greater than or equal to 1.0 x 10⁷/L, Platelets greater than or equal to 100 x 10⁹/L.

May proceed with doses as written, if indicated by protocol, within 24 hours of **Day 8 and 15:** ANC greater than or equal to 1.0 x 10⁷/L, Platelets greater than or equal to 100 x 10⁹/L.

Dose modification for:  □ Hematology  □ Other Toxicity ________________

Proceed with treatment based on blood work from ________________

**PREMEDICATIONS:**

- prochlorperazine 10 mg PO prior to treatment
- metoclopramide 10 mg PO prior to treatment
- Other:

**CHEMOTHERAPY:**

**DAY 1:**

- gemcitabine 800 mg/m² x BSA = ________ mg
- Dose Modification: __________ mg/m² x BSA = ________ 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 (select one) 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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**ORDERS CONTINUE ON PAGE 2…..**

**DOCTOR’S SIGNATURE:**

| SIGNATURE: |

| UC: |
**DOCTOR'S ORDERS**  

**BSA _________ m²**

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

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<tr>
<th>DATE:</th>
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<tr>
<td>Date of Previous Cycle:</td>
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**DAY 8:**

**gemcitabine 800 mg/m² x BSA = ________ mg**

☐ Dose Modification: ___________mg/m² x BSA = ________mg  
IV in 250 mL NS over 30 minutes.

**DAY 15:**

**gemcitabine 800 mg/m² x BSA = ________ mg**

☐ Dose Modification: ___________mg/m² x BSA = ________mg  
IV in 250 mL NS over 30 minutes.

**DOSE MODIFICATION** (If required for Day 8 and/or 15)

☐ Day 8 and 15   OR   ☐ Day 15 (select one)

**gemcitabine 800 mg/m² x BSA = ________ mg**

☐ Dose Modification: ________% = ___________mg/m² x BSA = ________mg  
IV in 250 mL NS over 30 minutes.

ORDERS CONTINUE ON PAGE 3.....

**DOCTOR'S SIGNATURE:**

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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: GOOVBEVG**

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<th>RETURN APPOINTMENT ORDERS</th>
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Return in **four** weeks for Doctor and Cycle _______. Book Chemo Day 1, 8, & 15.

- [ ] Last Treatment. Return in _______ week(s).

**CBC & Diff, Platelets, [ ] Laboratory urinalysis or [ ] Urine dipstick (select one) for protein prior to next Cycle (within 96 hours OK).**

- If Cycle #1, **CBC & Diff, Platelets** on Days 8 & 15.
- In subsequent Cycles, if indicated, **CBC & Diff, Platelets** on [ ] Day 8 and/or [ ] Day 15.

- [ ] **24 hour 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** [ ] **Creatinine**

- [ ] **LDH** [ ] **Tot Prot** [ ] **Albumin** [ ] **CA 15-3** [ ] **CA 125** [ ] **CA 19-9** [ ] **CEA**

- [ ] Other tests:

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

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BC Cancer Provincial Preprinted Order GOOVBEVG
Created: 1 Feb 2018 Revised: 1 Nov 2020