## DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
</tr>
</thead>
</table>

**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)
- [ ] CBC & Diff, Platelets day of treatment

May proceed with doses as written if within 72 hours **ANC greater than or equal to 1.0 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:

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

- [ ] CYCLE # 1

**PACLitaxel 175 mg/m² OR _______ 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) = _______ mg**

- [ ] Dose Modification: _______% = _______ mg

IV in 250mL NS over 30 minutes.

**ORDERS CONTINUE ON PAGE 2**

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**
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: GOOVCATB (Induction)

DATE:

OR □ CYCLE # _____ (cycle 2-6)

PACLitaxel 175 mg/m² OR ________ 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) = ______________ mg

□ Dose Modification: _________% = ___________ mg

IV in 250mL NS over 30 minutes.

Flush line with 25 mL NS pre-bevacizumab. Blood pressure measurement pre-bevacizumab dose.

bevacizumab 7.5 mg/kg x _____ kg = __________ mg

IV in 100 mL NS over 15 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>
</tr>
</thead>
<tbody>
<tr>
<td>bevacizumab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RETURN APPOINTMENT ORDERS

Return in three weeks for Doctor and Cycle _______.

□ Last Treatment. Return in ______ week(s).

CBC & Diff, Platelets, Creatinine, Laboratory urinalysis or Urine dipstick for protein prior to next cycle.

If this is Cycle 1: CBC & Diff, Platelets on Day 14.
In subsequent cycles, if indicated: CBC & Diff, Platelets on □ Day 14

□ 24 h 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 □ AST □ LDH
- □ Tot Prot □ Albumin
- □ CA 15-3 □ CA 125 □ CA 19-9

□ Refer to Hereditary Cancer Program (see accompanying referral form)

□ Consults:
□ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: □ SIGNATURE:

UC:

BC Cancer Provincial Preprinted Order GOOVCATB (induction)

Created: 1 Aug 2019   Revised: 1 Jul 2020