PROTOCOL CODE: GOOVCATB (Maintenance)

DOCTOR’S ORDERS

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)

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

Proceed with treatment based on blood work from __________________________

PREMEDICATIONS: Not usually required for bevacizumab

If ordered, patient to take own supply. RN/Pharmacist to confirm __________________________.

CHEMOTHERAPY:

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>
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</thead>
<tbody>
<tr>
<td>bevacizumab</td>
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RETURN APPOINTMENT ORDERS

Return in three weeks for Doctor and Cycle _________

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

Laboratory urinalysis or Urine dipstick for protein prior to next cycle.

□ 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:

□ CBC & Diff, Platelets □ Creatinine

□ Bilirubin □ Alk Phos □ GGT □ ALT □ AST □ LDH

□ Tot Prot □ Albumin

□ CA 15-3 □ CA 125 □ CA 19-9

Consults:

□ See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: SIGNATURE:

UC: