A BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

### 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 #: ____________

- 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 10⁹/L, Platelets greater than or equal to 100 x 10⁹/L.

May proceed with doses as written if BP less than or equal to 150/100, and, if indicated by protocol, within 24 hours of Day 8 and 15: ANC greater than or equal to 1.0 x 10⁹/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: ________________________________

**“Have Hypersensitivity Reaction Tray and Protocol Available”**

### 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 x weight = ______ mg IV in 100 to 250 mL NS over 30 minutes to 1 hour (over 1 hour if first bevacizumab infusion).

Flush line with 25 mL NS post-bevacizumab. Blood pressure measurement post-bevacizumab infusion in Cycles 1 to 3.

**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

<table>
<thead>
<tr>
<th>DATE:</th>
<th>To be given:</th>
<th>Cycle #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Previous Cycle:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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.

ORDERS CONTINUE ON PAGE 3....

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

Day 8 and 15  OR  Day 15  (*circle one*)

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

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

### DOCTOR’S SIGNATURE:

<table>
<thead>
<tr>
<th>SIGNATURE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>UC:</td>
</tr>
</tbody>
</table>
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](http://www.bccancer.bc.ca) and according to acceptable standards of care.

**PROTOCOL CODE: UGOOVBEVG**

**DATE:**

<table>
<thead>
<tr>
<th>RETURN APPOINTMENT ORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return in four weeks for Doctor and Cycle _______. Book Chemo Day 1, 8, &amp; 15.</td>
</tr>
<tr>
<td>☐ Last Treatment. Return in ______ week(s).</td>
</tr>
</tbody>
</table>

**CBC & Diff, Platelets, Laboratory urinalysis or Urine dipstick 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.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**