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

### DOCTOR’S ORDERS

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<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:**

<table>
<thead>
<tr>
<th>Date of Previous Cycle:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Delay treatment ______ week(s)</td>
</tr>
<tr>
<td>□ CBC &amp; Diff, Platelets day of treatment</td>
</tr>
</tbody>
</table>

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:

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

### 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: UGOOVVCATB (Induction)**

<table>
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</table>

**OR □ CYCLE # ____ (cycle 2-6)**

PACLitaxel 175 mg/m$^2$ OR ________ mg/m$^2$ (circle one) x BSA = ________ mg

☑ Dose Modification: ________% = ________ mg/m$^2$ 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 250 mL 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 UGOOVVCATB

Created: 1 Aug 2019  Revised: 1 Nov 2019