



Provincial Health Services Authority

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: CNBEV

DOCTOR'S ORDERS		Ht _____ cm Wt _____ kg BSA _____ m ²						
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form								
DATE:	To be given:	Cycle #:						
Date of Previous Cycle:								
<input type="checkbox"/> Delay treatment _____ week(s) May proceed with doses as written if within 96 hrs BP less than or equal to 150/100 , and Day 1 urine dipstick for protein negative or 1+ and, if ordered, if within 48 hrs ANC greater than or equal to 1.5×10^9/L , Platelets greater than or equal to 100×10^9/L , Creatinine clearance greater than or equal to 60 mL/min , ALT less than or equal to 5 x ULN , Bilirubin less than or equal to 25 micromol/L								
Dose modification for: <input type="checkbox"/> Hematology _____ <input type="checkbox"/> Toxicity _____								
PREMEDICATIONS: Not usually required for bevacizumab								
If ordered, patient to take own supply. RN/Pharmacist to confirm _____								
CHEMOTHERAPY: Check one bevacizumab dose								
<input type="checkbox"/> bevacizumab 10 mg/kg x _____ kg = _____ mg IV in 100 mL NS over 30 minutes (first infusion over 1 hour) on Days 1 and 15 .								
<i>Or</i>								
<input type="checkbox"/> bevacizumab 15 mg/kg x _____ kg = _____ mg IV in 100 to 250 mL NS over 30 minutes (first infusion over 1 hour) on Days 1 and 22 .								
Flush line with 25 mL NS pre and post dose. (Blood pressure measurement pre and post dose for first 3 cycles and prior to bevacizumab for subsequent cycles) Pharmacy to select bevacizumab brand as per Provincial Systemic Therapy Policy III-190								
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Drug</th> <th style="width: 40%;">Brand (Pharmacist to complete. Please print.)</th> <th style="width: 40%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">bevacizumab</td> <td style="padding: 2px;"></td> <td style="padding: 2px;"></td> </tr> </tbody> </table>	Drug	Brand (Pharmacist to complete. Please print.)	Pharmacist Initial and Date	bevacizumab				
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bevacizumab								
If using chemotherapy (Check one):								
<input type="checkbox"/> lomustine 90 mg/m² x BSA x (_____ %) = _____ mg PO once daily at bedtime on Day 1 every SIX WEEKS (Round dose to nearest 10 mg)								
<input type="checkbox"/> etoposide _____ mg PO (standard dose is 50 mg) once daily on Days 1 to 21								
DOCTOR'S SIGNATURE:	SIGNATURE:							
	UC:							

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DATE:	
RETURN APPOINTMENT ORDERS	
<input type="checkbox"/> Every two weeks bevacizumab Dosing: Return in four weeks for Doctor and Cycle _____. Book chemo on days 1 and 15. <input type="checkbox"/> Every three weeks bevacizumab Dosing: Return in six weeks for Doctor and Cycle _____. Book chemo on days 1 and 22. <input type="checkbox"/> Last cycle. Return in _____ weeks.	
<p>Dipstick Urine or laboratory urinalysis for protein at the beginning of each cycle</p> <p>If patient on lomustine: Before each lomustine treatment: CBC & Diff, Platelets, ALT, bilirubin, creatinine 28 days after each lomustine treatment: CBC & Diff, platelets</p> <p>If patient on etoposide: Before each cycle of etoposide: CBC & Diff, Platelets, creatinine</p> <input type="checkbox"/> 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 <input type="checkbox"/> CBC & Diff, Platelets, Creatinine prior to each Cycle <input type="checkbox"/> CT or <input type="checkbox"/> MRI (<i>select one</i>) every second cycle <input type="checkbox"/> If clinically indicated: <input type="checkbox"/> Tot. Prot <input type="checkbox"/> Albumin <input type="checkbox"/> Bilirubin <input type="checkbox"/> INR <input type="checkbox"/> Alk. Phos. <input type="checkbox"/> LDH <input type="checkbox"/> ALT <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Other tests: <input type="checkbox"/> Weekly Nursing Assessment <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.	
DOCTOR'S SIGNATURE:	SIGNATURE: UC: