



Provincial Health Services Authority

PROTOCOL CODE: BRAVLCAP

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/terms-of-use and according to acceptable standards of care.

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) <input type="checkbox"/> CBC & Diff day of treatment										
May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L , platelets greater than or equal to 75 x 10⁹/L , creatinine clearance greater than 50 mL/min .										
Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____										
Proceed with treatment based on blood work from _____										
TREATMENT:										
capecitabine 1000 mg/m ² x BSA x (_____ %) = _____ mg PO BID x 14 days on Days 1 to 14.										
Pharmacist to select dose band per last page of PPO. Complete table below (please print)										
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;">Drug</th> <th style="width:40%;">Dose Band (mg)</th> <th style="width:40%;">Pharmacist Initial and Date</th> </tr> </thead> <tbody> <tr> <td>capecitabine</td> <td> </td> <td> </td> </tr> </tbody> </table>					Drug	Dose Band (mg)	Pharmacist Initial and Date	capecitabine		
Drug	Dose Band (mg)	Pharmacist Initial and Date								
capecitabine										
lapatinib <input type="checkbox"/> 1250 mg or <input type="checkbox"/> _____ mg (select one) PO once daily on Days 1 to 21 (continuously). (Round dose to nearest 250 mg)										
RETURN APPOINTMENT ORDERS										
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____										
<input type="checkbox"/> Last Cycle. Return in _____ week(s).										
CBC & Diff, creatinine, total bilirubin, alkaline phosphatase, ALT prior to each cycle										
If clinically indicated:										
<input type="checkbox"/> echocardiogram <input type="checkbox"/> MUGA scan <input type="checkbox"/> ECG										
<input type="checkbox"/> INR weekly <input type="checkbox"/> INR prior to each cycle <input type="checkbox"/> sodium <input type="checkbox"/> potassium										
<input type="checkbox"/> Other tests:										
<input type="checkbox"/> Weekly nursing assessment for (specify concern): _____										
<input type="checkbox"/> Consults:										
<input type="checkbox"/> See general orders sheet for additional requests.										
DOCTOR'S SIGNATURE:				SIGNATURE:						
				UC:						

CAPECITABINE DOSE BANDING TABLE

Ordered Dose (mg)		Rounded dose (mg)	Number of Tablets Per Dose	
From:	To:		150 mg	500 mg
226	375	300	2	
376	475	450	3	
476	575	500		1
576	725	650	1	1
726	900	800	2	1
901	1075	1000		2
1076	1225	1150	1	2
1226	1400	1300	2	2
1401	1575	1500		3
1576	1725	1650	1	3
1726	1900	1800	2	3
1901	2075	2000		4
2076	2225	2150	1	4
2226	2400	2300	2	4
2401	2575	2500		5
2576	2725	2650	1	5
2726	2900	2800	2	5
2901	3075	3000		6
3076	3225	3150	1	6
3226	3400	3300	2	6
3401	3575	3500		7
3576	3725	3650	1	7
3726	3900	3800	2	7