

PROTOCOL CODE: GOCXCATB

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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) and repeat CBC & Diff on day of treatment May proceed with doses as written if within 96 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: <input type="checkbox"/> Hematology <input type="checkbox"/> 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 in NS 50 mL over 15 minutes and famotidine 20 mg IV in NS 100 mL over 15 minutes (Y-site compatible)				
AND select ONE of the following:	<input type="checkbox"/>	ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin		
	<input type="checkbox"/>	aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin, and ondansetron 8 mg PO 30 to 60 minutes prior to CARBOplatin		
	<input type="checkbox"/>	netupitant-palonosetron 300 mg-0.5 mg PO 30 to 60 minutes prior to CARBOplatin		
If additional antiemetic required:				
<input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin <input type="checkbox"/> Other: _____				
Have Hypersensitivity Reaction Tray and Protocol Available				
TREATMENT:				
PACLitaxel <input type="checkbox"/> 175 mg/m ² or <input type="checkbox"/> 155 mg/m ² or <input type="checkbox"/> 135 mg/m ² (select one) x BSA = _____ mg <input type="checkbox"/> 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 0.2 micron in-line filter)				
CARBOplatin AUC <input type="checkbox"/> 6 or <input type="checkbox"/> 5 (select one) x (GFR + 25) x = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250 mL NS over 30 minutes. Blood pressure measurement pre-bevacizumab dose.				
bevacizumab <input type="checkbox"/> 15 mg/kg or <input type="checkbox"/> _____ mg/kg (select one) x _____ kg = _____ mg IV in 100 to 250 mL NS over 30 minutes. (Blood pressure measurement post-bevacizumab infusion for first 3 cycles)				
Pharmacist to select brand per Provincial Systemic Therapy Policy III-190 and dose band per last page of PPO. Complete table below (please print)				
	Drug	Brand	Dose Band (mg)	Pharmacist Initial and Date
	bevacizumab			
DOCTOR'S SIGNATURE:				SIGNATURE:
				UC:

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DATE:	
RETURN APPOINTMENT ORDERS	
<p>Return in <input type="checkbox"/> three weeks, or <input type="checkbox"/> four weeks for Doctor and Cycle _____</p> <p><input type="checkbox"/> Last Treatment. Return in _____ week(s).</p>	
<p>CBC & Diff, creatinine, total bilirubin, ALT, laboratory urinalysis or urine dipstick for protein prior to next cycle (<i>within 96 hours OK</i>).</p> <p>CBC & Diff on <input type="checkbox"/> Day 14 <input type="checkbox"/> Day 21</p> <p><input type="checkbox"/> 24 hr 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</p> <p>Prior to next cycle, if clinically indicated:</p> <p><input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> GGT <input type="checkbox"/> LDH</p> <p><input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> magnesium <input type="checkbox"/> calcium</p> <p><input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> SCC <input type="checkbox"/> CEA</p> <p><input type="checkbox"/> Other tests:</p> <p>NB – Repeat any positive imaging after every 2 cycles.</p> <p><input type="checkbox"/> Consults:</p> <p><input type="checkbox"/> See general orders sheet for additional requests.</p>	
DOCTOR'S SIGNATURE:	SIGNATURE: UC:

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Bevacizumab Dose Banding Table

Ordered Dose (mg)		Rounded dose (mg)
From:	To:	
Less than 188		Pharmacy prepares specific dose
188	221.49	200
221.5	236.49	225
236.5	260.49	250
260.5	286.49	275
286.5	332.49	300
332.5	387.49	350
387.5	443.49	400
443.5	474.49	450
474.5	554.49	500
554.5	665.49	600
665.5	776.49	700
776.5	887.49	800
887.5	999.49	900
999.5	1099.49	1000
1099.5	1199.49	1100
1199.5	1299.49	1200
1299.5	1399.49	1300
1399.5	1499.49	1400
1499.5	1599.49	1500
1599.5	1699.49	1600
1699.5	1799.49	1700
1799.5	1899.49	1800
1899.5	1999.49	1900
1999.5	2099.49	2000
2099.5	2199.49	2100
2199.5	2299.49	2200
2299.5	2399.49	2300
More than 2399.49		Pharmacy prepares specific dose