



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: GOOVCATB (Induction)

(Page 1 of 3)

DOCTOR'S ORDERS

Ht _____ cm Wt _____ kg BSA _____ m²

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE:

To be given:

Cycle #:

Date of Previous Cycle:

Delay treatment _____ week(s)

CBC & Diff day of treatment

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 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:

OLANzapine **2.5 mg** or **5 mg** or **10 mg** (select one) PO 30 to 60 minutes prior to CARBOplatin

Other:

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

TREATMENT: (Note – continued over 2 pages)

CYCLE # 1

PACLitaxel **175 mg/m²** OR _____ **mg/m²** (select 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 0.2 micron in-line filter)

CARBOplatin AUC **6** or **5** (select one) x (GFR + 25) = _____ mg

Dose Modification: _____ % = _____ mg

IV in 100 to 250mL NS over 30 minutes.

ORDERS CONTINUE ON PAGE 2

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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: GOOVCATB (Induction)

(Page 2 of 3)

DATE:

OR **CYCLE #** ____ (cycle 2-6)

PACLitaxel **175 mg/m²** OR _____ **mg/m²** (select 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 0.2 micron in-line filter)

CARBOplatin AUC **6** or **5 (select one)** x (GFR + 25) = _____ mg

Dose Modification: _____ % = _____ mg

IV in 100 to 250 mL NS over 30 minutes.

Blood pressure measurement pre-bevacizumab dose.

bevacizumab 7.5 mg/kg x _____ kg = _____ mg

IV in 100 mL NS over 15 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			

RETURN APPOINTMENT ORDERS

Return in **three** weeks for Doctor and Cycle _____

Last Treatment. Return in _____ week(s).

CBC & Diff, creatinine, total bilirubin, ALT, laboratory urinalysis or urine dipstick for protein prior to next cycle.

If *clinically indicated*:

CBC & Diff 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

Prior to next cycle, if clinically indicated:

sodium **potassium** **magnesium** **calcium**

alkaline phosphatase **GGT** **LDH**

CA 15-3 **CA 125** **CA 19-9** **CEA** **SCC**

Refer to Hereditary Cancer Program (see accompanying referral form)

Consults:

See general orders sheet for additional requests.

DOCTOR'S SIGNATURE:

SIGNATURE:

UC:



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: GOOVCATB (Induction)

(Page 3 of 3)

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