

Doctor's Order Sheet
CAPOX Mvasi® (bevacizumab)
Regimen:
**OXALIplatin 130 - capecitabine
1000 - Mvasi® (bevacizumab)
7.5 mg/kg (Part I)**

Name: _____
HCN: _____
Date of Birth: _____

ARIA Protocol Name: CAPOX Mvasi (bevacizumab)
Adult Chemotherapy - Medical Oncology
Metastatic Colorectal Carcinoma



CC3150 0126 08 2020

Allergies: No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY
Cycle of **Cycle Duration: 21 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.2 X 10⁹/L and platelets **greater than or equal to** 75 X 10⁹/L, otherwise notify Medical Oncologist
- BP **less than or equal to** 160/100mmHg, otherwise notify Medical Oncologist
- Creatinine Clearance **greater than or equal to** 50 mL/minute, otherwise notify Medical Oncologist
- LFT's and Bilirubin assessed
- Dipstick Urine or laboratory urinalysis for protein at the beginning of each odd (1, 3, 5) numbered cycle. If results are 2+ or 3+ or greater than or equal to 1 g/L laboratory urinalysis for protein, collect 24-hour urine for total protein within 3 days before the next cycle.
If this result is abnormal, dose reductions are required.

PREMEDICATIONS (FOR HOSPITAL PHARMACY):

- ondansetron 8 mg PO on day 1
- dexamethasone 8 mg PO on day 1
- Other: _____

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT.

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.

Doctor's Order Sheet
CAPOX Mvasi® (bevacizumab)

Regimen:

**OXALi_{platin} 130 - capecitabine
1000 - Mvasi® (bevacizumab)
7.5 mg/kg (Part II)**

ARIA Protocol Name: CAPOX Mvasi (bevacizumab)
Adult Chemotherapy - Medical Oncology
Metastatic Colorectal Carcinoma



CC3150 0126 08 2020

Name: _____

HCN: _____

Date of Birth: _____

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

- OXALi_{platin} 130 mg/m² X BSA = _____ mg**
 - Dose modification: **OXALi_{platin} 130 mg/m² X BSA - _____ % = _____ mg**
 - IV** in 500 mL D5W over 120 minutes on day 1
- Mvasi® (bevacizumab) 7.5 mg/kg X weight (kg) = _____ mg**
 - IV** in 100 mL normal saline on day 1 over:
 - **90** minutes during **Cycle 1**;
 - If tolerated without reaction - **60** minutes during **Cycle 2**;
 - If tolerated without reaction - **30** minutes during **Cycle 3**;
 - If tolerated without reaction - **15** minutes during **Cycle 4** and all other cycles

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- capecitabine 1000 mg/m² X BSA = _____ mg**
 - Dose modification: **capecitabine 1000 mg/m² X BSA - _____ % = _____ mg**
 - PO** bid with food on days 1 to 14

This prescription is NOT eligible for medication management by a pharmacist.

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT.

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

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