CANCERCare
A PROGRAM OF EASTERN HEALTH
Cancer Care Program

Doctor's Order Sheet
CAPOX Avastin® (bevacizumab) Regimen

OXALIplatin 130 - capecitabine 1000 - Avastin® (bevacizumab) 7.5 mg/kg (Part I)

Name:

HCN:

Date of Birth:

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

CC1340 0005 09 2020

Allergies: ☐ **No Known**

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

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1.2 X 10^9/L and platelets **greater than or equal to** 75 X 10^9/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.

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Doctor's Order Sheet
CAPOX Avastin® (bevacizumab) Regimen:

OXALIplatin 130 - capecitabine 1000 - Avastin® (bevacizumab) 7.5 mg/kg (Part II)

Name:

HCN:

Date of Birth:

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

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Weight: _____kg Height:_____cm Body Surface Area (BSA) = _____

CHEMOTHERAPY (FOR HOSPITAL PHARMACY):

☐ **OXALIplatin 130 mg/m²** X BSA = _____**mg**

☐ Dose modification: **OXALIplatin 130 mg/m²** X BSA - _____% = _____**mg**

IV in 500 mL D5W over 120 minutes on day 1

☐ **Avastin® (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: _____