

Doctor's Order Sheet  
**FOLFIRI Mvasi® (bevacizumab)**  
 Regimen:  
**irinotecan 180 - leucovorin**  
**400 - fluorouracil 400 -**  
**fluorouracil 2400 - Mvasi®**  
**(bevacizumab) 5 mg/kg (Part I)**  
**ARIA Protocol Name: FOLFIRI Mvasi (bevacizumab)**  
 Adult Chemotherapy- Medical Oncology  
 Metastatic Colorectal Carcinoma

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



CC3160 0127 08 2020

**Allergies:**  **No Known**

Date: DD/MONTH/YYYY

Planned Administration Date: DD/MONTH/YYYY

**MAY PROCEED WITH DOSES AS WRITTEN IF:**

- ANC **greater than or equal to**  $1.5 \times 10^9/L$  and platelets **greater than or equal to**  $75 \times 10^9/L$ , otherwise notify Medical Oncologist.
- BP **less than or equal to** 160/100mmHg, otherwise notify Medical Oncologist.
- LFTs 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 16 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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 Regimen:  
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**400 - fluorouracil 400 -**  
**fluorouracil 2400 - Mvasi®**  
**(bevacizumab) 5 mg/kg (Part II)**

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

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



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

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

- irinotecan 180 mg/m<sup>2</sup> X BSA = \_\_\_\_\_ mg**  
 Dose modification: **irinotecan 180 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**  
**IV in 500 mL D5W over 90 minutes on day 1**
- leucovorin 400 mg/m<sup>2</sup> X BSA= \_\_\_\_\_ mg**  
**IV in 250 mL D5W over 90 minutes on day 1**
- fluorouracil 400 mg/m<sup>2</sup> X BSA= \_\_\_\_\_ mg**  
 Dose modification: **fluorouracil 400 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**  
**IV push on day 1**
- fluorouracil 2400 mg/m<sup>2</sup> X BSA= \_\_\_\_\_ mg**  
 Dose modification: **fluorouracil 2400 mg/m<sup>2</sup> X BSA - \_\_\_\_\_ % = \_\_\_\_\_ mg**  
**IV in D5W continuously over 46 hours**
- Mvasi® (bevacizumab) 5 mg/kg X weight (kg) = \_\_\_\_\_ mg**  
**IV in 100 mL normal saline on day 1 over 10 minutes**

**HYDRATION/SUPPORTIVE CARE (FOR HOSPITAL PHARMACY):**

**atropine 0.4 mg IV prn** for early diarrhea, abdominal cramps, rhinitis, lacrimation, diaphoresis, or flushing.

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Authorized Prescriber's Signature: \_\_\_\_\_ ID #: \_\_\_\_\_

Nurse's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY Time: \_\_\_\_\_

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