

Doctor's Order Sheet  
**Zirabev® (bevacizumab)**  
**7.5 mg/kg Regimen**

**ARIA Protocol Name:** Zirabev (bevacizumab) 7.5  
Adult Chemotherapy – Gynecologic Cancer  
Epithelial Ovarian, Primary Peritoneal, or Fallopian Tube Carcinoma Therapy

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

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

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



CC3510 0162 07 2022

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

**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**  $1.5 \times 10^9/L$  and platelets **greater than or equal to**  $100 \times 10^9/L$ , otherwise notify Gynecologic Oncologist
- BP **less than or equal to** 150/100mmHg, otherwise notify Gynecologic Oncologist
- LFTs and Bilirubin assessed
- Assess dipstick urine or laboratory urinalysis for protein

**PREMEDICATIONS:**

Other: \_\_\_\_\_

**CHEMOTHERAPY (FOR HOSPITAL PHARMACY):**

Zirabev® (bevacizumab) 7.5 mg/kg X weight (kg) = \_\_\_\_\_ mg

IV in 100 mL normal saline on day 1 over:

- **60** minutes during **Cycle 1**;
- If tolerated without reaction - **15** minutes during **Cycle 2** and all other cycles

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.